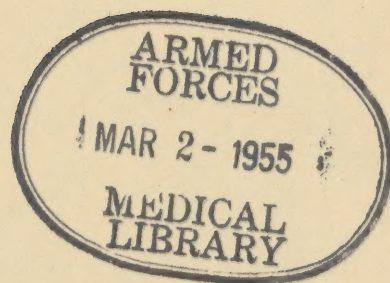


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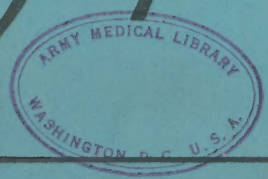
GENERAL HEADQUARTERS

SUPREME COMMANDER for the ALLIED POWERS

IV PUBLIC HEALTH and WELFARE SECTION



*Public Health and Welfare
in
Japan*



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-- Foreword --

Public Health and Welfare in Japan has been designed to portray the problems, activities and future programs of the Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers, in furthering the health and welfare objectives of the occupational mission. It provides a historical background and pre-surrender status of health and welfare in Japan, in addition to a factual review of the progress made from the beginning of the occupation to 31 July 48

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SECTION I

Historical Background

Chapter 1

THE NATIONAL LEVEL

The opening of Japan's door to the Western World in 1853 and the implantation of Western culture which followed, ultimately had a direct influence on the government's recognition of the necessity of providing for the health and welfare needs of its people.

During the ensuing 20 year period many unsuccessful attempts were made to adopt some form of a public health and welfare program. Finally in 1873 a Medical Bureau was established in the Department of Education and became the first such body created in Japan to control medical education and sanitary administration. The first unified statute called "The Medical Code" was published by this Bureau in 1874.

In 1875 the Medical Bureau was renamed the "Seventh Bureau" and transferred to the Ministry of Home Affairs where it became an agency for the exclusive management of sanitary activities. Later renamed the Sanitary Bureau, it was then subdivided into four sections: Health Preservation, Chronic Disease Prevention, Communicable Disease Prevention and Medical Affairs.

The first measures for the prevention of infectious diseases were taken in April 1875 by Imperial Decree No. 49 of the Supreme Council of the Empire (Regulations for the relief of the poor during the prevalence of epidemics).

In February 1876 Ordinance No. 12-B of the Home Department was enacted which instructed physicians to report the condition of patients attended by them, who were suffering from epidemic diseases.

Ordinance No. 16-A of the Home Department, passed in May of 1876, established regulations for the prevention of smallpox. Ordinance No. 79-B of the Home Department, passed in August of 1877, provided for preventive measures in cases of cholera. Imperial Decree No. 23 of the Supreme Council of the Empire, issued in June 1879, established provisional regulations for the prevention of cholera.

Imperial Decree No. 23 also provided for Regulations for the Prevention of Infectious Diseases, the following diseases becoming reportable in July 1880: cholera, typhoid fever, dysentery, typhus, smallpox, diphtheria.

By Law No. 36, Prevention of Infectious Diseases, enacted in April 1897, plague and scarlet fever were made reportable in addition to the six infectious diseases listed above, at which time the Regulations for the Prevention of Infectious Diseases were abrogated.

Paratyphoid fever and epidemic meningitis were designated as infectious diseases in April 1911 and April 1918, respectively, and came under the provisions of Law No. 36.

While it might appear that the creation of the Sanitary Bureau and the preventive measures taken toward infectious diseases would foster

the control of health and welfare activities, the Bureau's lack of authority and its inexperienced and incompetent staff failed to properly administer health and sanitary responsibilities. This retarded any worthwhile progress. It continued to function, however, with minor changes until 1938.

Chapter 2

PREFECTURAL AND LOCAL ORGANIZATION

Prefectural and local programs for the administration of the Sanitary Bureau's responsibilities were vested with the prefectural governors, police chiefs, and chiefs of towns and villages. The Ministry of Home Affairs exercised indirect control and provided advisory guidance depending upon the matters involved. In routine affairs the prefectural and local organizations were invested with wide discretionary powers.

A health section, including laboratories, was attached to each prefectural police department to handle all public health activities. The head of the health section was appointed by the Ministry of Home Affairs with the approval of the Emperor. Cities, towns and villages had authority to adopt local public health ordinances. Municipal health officials were appointed by the mayor, with the consent of the local assembly, and cooperated with the chiefs of the police in administering and supervising sanitary matters.

Each village, depending on size, had a Sanitation Bureau or a Sanitation Officer who was responsible for all matters concerning sanitation. They enforced local sanitary ordinances and supervised vaccinations. In addition, the village officials maintained a doctor for prescription health examinations and annual smallpox vaccinations. Local police assisted village officials in carrying out their public health duties and were called upon to enforce rules which were not obeyed.

At the various levels of prefectural and local organizations, there was a considerable overlapping of the duties of the police and other civil administrative officials.

Chapter 3

THE MINISTRY OF WELFARE

Repeated attempts to encourage the establishment of a national governmental organization to be responsible for the over-all health and welfare problems of the nation had met with little success. However, the rapid industrialization of the nation following the Sino-Japanese, Russo-Japanese and the First World War, with its resultant booms and depressions, coupled with rice riots in 1918, forced the government's hand in establishing a national agency. In addition, the army was finding too many tuberculosis rejectees and became gravely concerned about the deterioration of the health of the young men eligible for military duty.

In 1937 the government decided to create a national organization and on 11 January 1938, by Imperial Ordinance No. 7, the Ministry of Health and Social Affairs (now known as the Ministry of Welfare) was established and made responsible for the health and welfare of the civilian population, labor administration and social insurance.

The Ministry was subdivided into the Ministerial Office with Divisions for Secretariat, General Affairs and Accounts; Bureaus for Physical Training, Sanitation, Preventive Medicine, Social Affairs, and Labor; and an Insurance Department with Divisions for General Affairs, Social Insurance and Post Office Life Insurance. The Ministry also controlled the National Hygienic Laboratory, the National Leprosarium, the National Juvenile Reformatories and the Infectious Disease Research Institute.

Following the establishment of the Ministry of Welfare the government transferred the Sanitation Bureau from the Ministry of Home Affairs to the new ministry. All public health and welfare activities of the nation then became the responsibility of this Ministry. In the prefectural and local governments the original administrative setup was preserved but came under the authority of the Ministry of Welfare.

From 1938 to 1945 the Ministry of Welfare underwent several reorganizations. In April 1938 a Department for the Protection of Wounded Veterans was created to take care of the sick and wounded soldiers from the war in China. In 1938 this Department extended aid to the families of soldiers who were killed in action and simultaneously changed its name to the Department of Soldiers' Protection. In 1941 the Bureau for Physical Training became the Bureau for Population but two years later was renamed the Bureau for Health Promotion.

The Bureau for Preventive Medicine was abrogated in 1942 and its duties divided between the Bureaus for Physical Training and Sanitation. Meanwhile, the Bureau for Social Affairs was redesignated the Bureau for Livelihood but was later abolished in 1944 when its functions were transferred to the Bureau of Health Promotion. Likewise in 1942 a new Bureau for Occupation was established but the following year was changed to the Bureau for Labor Exchange. This same year the Insurance Department was abolished when the Post Office Life Insurance Section was transferred to the Ministry of Communications. The General Affairs Section was then abolished when the Social Insurance Section was changed to Bureau status.

The constant administrative changes, plus frequent transfers of responsibilities, did little to perpetuate a good public health and welfare program.

Chapter 4

WORLD WAR II ADMINISTRATION

During the war increased industrialization and urbanization in the four main islands of Japan, plus the dominance of military aims over all social welfare activities, had a pronounced influence on public health and welfare administration.

Pressure of militarism brought greater emphasis on such emergent requirements as a rapid turn out of medical students, nurses and dentists. It also resulted in the cessation of many public health activities of benefit to the civilian population. The conversion of many factories, engaged in the manufacture of medical and sanitary supplies and equipment, to war materiel production, plus the lack of adequate professional people to serve the civilian population, resulted in a complete breakdown of all public health and welfare functions.

From the national to the lowest level the entire administration of public health and welfare activities became disorganized. Lack of trained personnel and low salaries paid to its own staff characterized the existing situation. Incompetent officials, charged with crucial responsibilities for public health, likewise seriously affected the efficiency of the entire organization. In addition, the Ministry of Welfare had not been permitted to assume its proper place in the Japanese government and many of the activities generally associated with public health and welfare were the responsibilities of other Ministries.

Chapter 5

CONDITIONS AT THE TIME OF SURRENDER

Upon the arrival of the Occupation Forces, the Japanese public health and welfare activities were found to be in a very demoralized state and practically inoperable.

An unsound administration, plus the nation's efforts to gear itself during the war, had completely broken down any semblance of health or welfare functions. No efforts were being made to complete public health reports, and transportation and communication facilities were damaged to such an extent that it was difficult to obtain information except from a few prefectures.

NOTE: No attempt has been made in this chapter to furnish a complete informational background of the health and welfare problems that confronted the Occupation Forces. However, under Section III, each specific subject covered has a detailed introductory paragraph on conditions pertaining to that particular program.

SECTION II

Public Health and Welfare Section

Chapter 1

MISSION AND ORGANIZATION

An organization to handle the public health and welfare problems which were expected to be encountered in Japan following the planned invasion was organized in May 1945, in Washington, D.C. This provided for a Military Government Section of General Headquarters, United States Armed Forces, Pacific (GHQ USAFPAC) which included a Public Health and Welfare Division.

In August of 1945, at Manila, Military Government Section of GHQ USAFPAC was established, but the sudden capitulation of the Japanese Government resulted in a modification of this plan shortly after arrival of the Occupation Forces in Japan. Military Government Section of GHQ USAFPAC was abolished and GHQ SCAP established.

Personnel of Public Health and Welfare Division of Military Government Section were transferred to the Public Health and Welfare Section of SCAP which was established on October 2, 1945, by authority of General Order No. 7, GHQ, SCAP. The Section was made responsible for the prevention of widespread diseases and unrest in the civil populations of both Japan and Korea. Korea has since been deleted from SCAP control and, at the same time, SCAP assumed the responsibility for technical supervision over Military Government activities in the Ryukyus Islands.

The Public Health and Welfare Section was also made responsible for the establishment or reestablishment of normal health control procedures, and with expediting the establishment of essential public health and welfare activities. It was charged with requiring the agencies of the Japanese Government to establish such standards of health, sanitation and quarantine in connection with repatriation of displaced persons as will prevent interference with the success of the occupation mission.

The Section is required to coordinate for SCAP, all essential reports pertaining to health and welfare and the production and distribution of medical, dental, veterinary, and sanitary supplies and equipment. In addition, it is responsible for the disposal of existing narcotic stocks, as well as the control of production and traffic in narcotics.

The Section recommends and directs the conduct of such surveys of public health and welfare activities as are essential to keep the Supreme Commander factually informed, and prepares instructions for the initiation, coordination and development of such plans and programs as are required to meet the public health and welfare objectives.

The Section is organized into 12 divisions and 25 branches (see chart No. 1) which cover all of the activities of the Ministry of Welfare, Japanese Government, thus permitting close coordination of all programs and activities necessary for an adequate public health and welfare organization.

SECTION III

Public Health and Welfare Programs

Chapter 1

JAPANESE ADMINISTRATION

Reorganization of the Ministry of Welfare

To permit the Ministry of Welfare to assume its proper place in the Japanese Government, with sufficient authority and responsibility to carry out necessary public health and welfare objectives, SCAPIN 945 (SUPREME COMMANDER for the ALLIED POWERS INSTRUCTIONS) dated 11 May 1946, directed the Japanese Government to immediately reorganize the administration of health and welfare activities by establishing the following bureaus:

1. Bureau of Health - to be responsible for public health, health education, vital statistics and nutritional activities.
2. Bureau of Medical Treatment - to be responsible for administration of hospitals, sanatoria, leprosaria, medical affairs, medical relief programs, pharmaceutical affairs, drug production and pharmaceutical standardization.
3. Bureau of Preventive Medicine - to be responsible for sanitary engineering, communicable and chronic infectious diseases.
4. Bureau of Social Affairs - to be responsible for public assistance, public welfare and the procurement and disposition of materials necessary to implement such functions.

The Ministry was given the full responsibility for the production and distribution of all medical and sanitary supplies and equipment, including the control of narcotics. A Children's Bureau has also been established and is responsible for child problems, including maternal and infant care. The reporting of Vital Statistics, which had been the responsibility of the Cabinet Bureau of Statistics, was transferred to the Public Health Statistical Section, Bureau of Public Health, Ministry of Welfare.

In July 1948 a further reorganization of the Ministry of Welfare took place, in which a re-grouping of the various departments, bureaus and sections provides for more efficient coordination of the nation-wide public health and welfare program. A new Pharmaceutical and Supply Bureau was organized, replacing the Pharmaceutical Affairs Section, Drug Manufacturing Section and the Supply Section, formerly under the Medical Affairs Bureau. A Public Sanitation Bureau replaced the former Public Health Bureau, and elevated to section status were the Food Sanitation Section, the Veterinary Affairs Section and the Environmental Sanitation Section.

The reorganization also included the changing of the First Demobilization Bureau to the Repatriation Relief Agency, responsible to the Minister of Welfare.

As now organized (see chart No. 2), the Ministry provides for a logical grouping of the four basic functions essential to an adequate national health and welfare program; preventive aspects of public health, medical care, social welfare and social security.

One of the significant changes in the reorganization of the Ministry of Welfare concerns the former career government employees who were required to be graduates of the Tokyo University School of Law and, as career officials, controlled all key positions in the National Government down to and including bureau chiefs. These former officials have been replaced by qualified professional personnel who now head the various activities in the government, including the Ministry of Welfare.

The framework for adequate administration of health and welfare activities has been established at the national level. Although future changes will undoubtedly take place to more effectively coordinate the administration of health and welfare functions, the Ministry of Welfare as now constituted is able to efficiently conduct all essential public health and welfare activities.

Prefectural and Local Reorganization

SCAPIN 945 further directed the Japanese Government to establish in each prefecture a Department of Health and a Department of Welfare whose functions will include those as outlined in the Ministerial Bureaus and to act as the operating agency for prefectural public health and welfare activities. Under the supervision of the prefectural welfare departments an organization of social welfare workers was established to administer provisions of the welfare programs.

In conjunction with the reorganization of the Ministry of Welfare and the prefectural governments, a program was initiated to provide for the reorganization of nationwide health centers, not only to include the 12 basic services considered essential, but to make health center districts the basic administrative units in the over-all national public health and welfare program.

The Health Centers

Introduction

In the early 1930's, the Ministry of Home Affairs established several Health Guidance Centers throughout Japan. The exact purpose and function of these centers is somewhat vague, although best available information indicates they served primarily to offer guidance on health matters to the general public, in addition to examinations for tuberculosis, which had become quite prevalent among the younger generation.

In 1937 the Japanese Government passed the first Health Center law and subsequently established the first health center in Chiba Prefecture. By 1938, 50 similar health centers had been established in various parts of Japan patterned after the original health center. The primary function of these health centers was the advancement of health education, examination for and control of tuberculosis and examinations for venereal disease. They also offered some maternal and child welfare guidance.

The health center facilities varied from large, well constructed buildings, strategically located, to small, deteriorated buildings, poorly located with no uniform administrative organization. They were sponsored by the national government but under the control of the prefectural government. They functioned poorly, suffered from lack of trained personnel and proper supplies and equipment, and generally contributed little to the public health.

There were approximately 645 such health centers in existence at the beginning of the occupation most of which had been damaged.

Reorganization

The health center organization has a great potential value in the control of communicable diseases and in promoting the general public health. Because

it was necessary that Public Health and Welfare Section personnel and Japanese public health officials occupy themselves in the control of acute communicable diseases, and other work of an emergency nature during the first year of the Occupation, it was not possible to devote much attention to the reorganization of the health centers. However, they were permitted to continue to carry on their work in accordance with the existing Health Center Law.

Early in 1947, when the urgency of controlling various communicable diseases diminished, action was initiated to expand and improve the functions of the health centers. Japanese officials had a poor conception of what the services of a health center should consist, so accordingly, the government was directed to present necessary reorganizational plans which would include the following 12 basic services:

1. Public health nursing.
2. Maternal and child hygiene.
3. Public health statistics.
4. Diagnostic laboratory services.
5. Dental hygiene.
6. Nutritional services.
7. Sanitation and hygiene.
8. Health education.
9. Medical social service.
10. Communicable disease control.
11. Venereal disease control (including diagnosis and treatment).
12. Tuberculosis control (including diagnosis and treatment).

After considerable planning a new Health Center Law (Public Law 101) passed the Diet on 5 September 1947. In addition, an enforcement ordinance, an enforcement regulation, and enforcement instructions were issued by the Ministry of Welfare to all prefectural governors, setting forth all the requirements of this new Health Center Law. A supplemental budget provided for increases in personnel and equipment.

It was then anticipated that rapid expansion and improvement of health centers would follow. However, the 1947 Local Autonomy Law, which decentralized powers of the national government, caused some confusion with the authority of the local governors in implementing the Health Center Law, and in order to clarify the situation the Local Autonomy Law was amended on 7 December 1947 leaving the way fully clear to reorganize and expand the health centers and to establish health center districts as originally planned.

The health centers are the administrative and service units for carrying out the details of the nation's public health program. They are a fundamental part of the public health organization, since they are that part of the organization with which the public is most intimately associated.

Model Health Center Demonstration

In order to provide key Japanese public health and welfare personnel with the modern concepts of how a health center should function the Public Health and Welfare Section arranged a model health center demonstration in Tokyo in March 1948. The health center selected was reconditioned and competently staffed and equipped to provide all the essential basic services.

Military Government public health officers, public health nurses, welfare officers and sanitary officers from each team in Japan and selected Japanese national and prefectural public health and welfare officials from each of the 46 prefectures were invited to attend.

The program consisted of six, one-week each, demonstrations which were given to some 400 persons. Visual and auditory aids were extensively used and lectures included both demonstration and application of health center activities.

The six courses were enthusiastically attended and provided Japanese personnel an opportunity to observe the physical and equipment facilities and functions of a modern health center. They were directed to establish a similar model health center in each prefecture in Japan as a basis for the prefectural health center reorganization program.

The National Program

Currently being accomplished is the constructing and equipping of model health centers in each prefecture in Japan. Upon the establishment of this model health center rests the establishment of similar health centers throughout each prefecture, depending upon the population and need.

The present program provides for one health center district for each 100,000 population, (780 in all) and in each health center district one main health center, properly staffed, organized and operated to efficiently serve the public health needs of the community. The health center district may have, in addition to the main health center, as many branches as necessary to meet the public health needs of the district.

Each health center district will have a qualified public health officer (doctor) who will also be the director of the main health center. Each district public health officer will, under the supervision of the Japanese prefectural health officer, be responsible for the administration of all public health functions within his district.

The first prefectural model health center to be opened since the demonstration in Tokyo was completed in June 1948 in the City of Morioka, Iwate Prefecture. Subsequent model health centers have been opened in Tokuyama City, Yamaguchi Prefecture, on 10 July; in Nagoya City, Aichi Prefecture, on 17 July; in Akita City, Akita Prefecture, on 25 July; in Fukushima, Fukushima Prefecture, on 30 July; and on 31 July in Utsunomiya, Tochigi Prefecture, and the City of Fukuoka, Fukuoka Prefecture.

Prefectural reports on the health center program indicate that construction of model health centers in each prefecture is proceeding satisfactorily and that many additional centers are scheduled for opening during the months of August and September.

Future Programs

The success of the national public health and welfare program is largely dependent upon its administrative organization. The Ministry of Welfare at the national level and the prefectures at the prefectural level have now been reorganized.

Reorganization of the health centers is the third and final step in the reorganization of the nation's public health and welfare system. The establishment of the model health centers in each prefecture and the organization of the health center districts will be pushed to completion to provide for continuous uniform public health administration, at all levels of government.

Chapter 2

PREVENTIVE MEDICINE

Communicable Disease ControlIntroduction

Japanese standards of sanitation and public health practices were, in most all instances, far below those of the more progressive nations. Standards they had attempted to maintain had been allowed to deteriorate due to the diversion of labor and materials to the war effort.

Public water and sewerage systems, which existed only in the larger cities, had been severely damaged as the result of bombings. Those that escaped war damage were in need of considerable repair.

Vaccination programs against such diseases as smallpox were either completely discontinued or were not enforced.

Environmental sanitation was virtually non-existent presenting a definite threat to the possibilities of an epidemic of diarrhea, dysentery, typhoid or other enteric diseases.

Smallpox--Introduction--

Smallpox was the one disease which was controlled by a fairly adequate existing law. However, enforcement had not been carried out during the war years and, as a result, a large portion of the population was found to be nonimmune. The incidence of smallpox had been steadily increasing since 1940 and upon the arrival of the Occupation Forces was found to be increasing rapidly.

The need for prompt and vigorous control measures was recognized, however, vaccine was not immediately available and there were many problems that had to be solved before adequate amounts of a standardized vaccine could be manufactured.

Steps taken to control local outbreaks were not sufficient to prevent an epidemic which developed rapidly and reached its peak in March 1946, when a total of 6,304 cases were reported for that month.

--Results Attained--

Smallpox vaccine was produced as rapidly as possible. Immunizations succeeded in bringing the epidemic under control during the spring and early summer of 1946 but not until more than 17,000 cases had occurred among the civilian population. Although cases occurred throughout Japan, the prefectures of Hokkaido, Tokyo, Kyoto, Osaka and Hyogo had by far the largest rate. During the summer of 1946 a large scale program was carried out in which the entire 78,000,000 people in Japan were vaccinated. This was one of the largest mass immunization programs ever attempted and illustrates the effectiveness of immunization rapidly bringing under control one of the most dreaded communicable diseases. (See chart No. 3).

This mass immunization program has practically eliminated smallpox as a major public health problem. A small number of cases have occurred, most of which have been sporadic, and only in a few instances have there been more than one or two cases in an area.

The control program in effect involves the immunization of the entire village or town when a case of smallpox occurs. Large outbreaks have thus been prevented. In addition to focal immunizations, the routine immunization program for infants and children has been carried out in conformance with the new immunization laws.

The effectiveness of the present control program is demonstrated by the fact that only 21 cases, all sporadic, have occurred during the past six months.

The Preventive Vaccination Law passed by the Diet on 1 July 1948 requires immunization in infancy and re-immunization before entering school, and again at the completion of elementary school. The law further provides that in cases of threatened epidemics all persons living in the threatened area will be immunized or re-immunized.

--Future Plans--

Smallpox is no longer a major public health problem. Future programs designed to eradicate this disease consists of focal immunizations, wherever cases occur, and routine immunization and re-immunization of infants and children in conformity with the existing law.

Typhus

--Introduction--

Typhus fever has been endemic in Japan for many years dating back at least to the last century. Unfortunately, in case reporting, no distinction was made between epidemic and murine typhus. In the immediate five year period prior to 1946, typhus was reported as follows: 1941 - 81 cases, 1942 - 100 cases, 1943 - 1,414 cases, 1944 - 3,964 cases, 1945 - 2,392 cases. Most of these cases centered in Hokkaido, which the Japanese claim had been imported by Korean slave laborers. From 1 January 1945 to 1 September 1945, 1,882 cases were reported of which 1,085 were from Hokkaido.

--Results Attained--

Following the confirmation of the presence of typhus in Hokkaido in October 1945, control measures were promptly initiated in an effort to prevent an epidemic. An attempt was made to halt the spread of typhus across the Tsugaru Straits into Honshu but this action came too late due to the uncontrolled movement of Koreans, from Hokkaido, who were endeavoring to return to Korea between 16 August and the arrival of the Occupation Forces.

The disease was carried south and in December 1945 reached epidemic proportions in Osaka. The epidemic spread rapidly to Kobe, Nagoya, Tokyo and vicinities where the majority of the cases occurred. Approximately 32,000 cases were reported between 1 January and 1 July 1946.

Typhus vaccine, DDT and other control supplies were not available from indigenous sources and had to be imported from the United States. An extensive program was started beginning in January 1946. Despite the handicap of inadequate supplies and improperly trained Japanese public health personnel, control measures were vigorously pursued and the epidemic abruptly halted. The peak was reached in March 1946 instead of May, the peak month in previous years. A total of 32,435 cases were reported between 1 September 1945 and 31 August 1946. (See chart No. 4).

Case finding teams, vaccinating teams, DDT dusting teams and insect and rodent control teams played a very important part in the typhus control program. Approximately 17,000,000 people were dusted with DDT and 5,300,000 vaccinated during the first year of the occupation. Education of the public through the media of the radio, press, pamphlets and posters was promoted with great success.

During the second year of the occupation control measures, which had worked so successfully, were continued and expanded. Under supervision, Japanese personnel have been most effective in carrying out this program. During the second occupational year there were approximately 1,600 cases of typhus reported as compared to the 32,435 reported the previous year. There have been no further large outbreaks. (See chart No. 4).

Although a large portion of the typhus vaccine used was imported from the United States, the Japanese have been instructed in the preparations of the vaccine and have produced considerable quantities for which minimum standards have been established. They are now able to meet all future requirements without the necessity of further imports.

During the second occupational year approximately 4,231,000 people were dusted with DDT, in addition to large numbers of school children whose heads were dusted in order to control head lice. Approximately 3,592,700 were immunized.

Additional improvements and modifications in typhus control techniques have continued to be made. Intensive training courses for the benefit of Japanese prefectural health officers, laboratory technicians and other public health personnel were conducted covering the important phases of typhus control. Dissemination of information concerning typhus fever, lice, fleas and rodents to the people of Japan through all media of transmission was continued.

Extended immunization programs were accomplished on: (1) inmates and personnel of all national prisons, reformatories and juvenile courts (approximately 165,300 persons); (2) railway employees (approximately 300,000) and (3) miscellaneous immunizations (approximately 6,250,000).

DDT dusting stations were established in nearly every large city of Japan in addition to the routine dusting operations in the neighborhood of reported typhus cases. DDT residual spray operations were carried out in prisons, reformatories, jails, detention homes, dormitories, railway stations, theatres, orphanages, public baths, railway coaches, busses, streetcars and miscellaneous public conveyances at 30 day intervals in which approximately 250,000 gallons of DDT residual spray was used.

Case finding was intensified and case reporting accelerated. Serological tests were made on serum samples taken from the great majority of suspect cases reported.

Results from a random sample group are quoted:

257 suitable specimens - 51.0% positive

49.0% negative

Epidemic typhus - - - - 47.5%

Murine typhus - - - - 29.3%

Not differentiated - - 23.2%

From results, such as indicated above, a much clearer picture of typhus fever has been obtained.

During the period from August 1947 to March 1948, a total of 347 cases of typhus were reported with a peak of 96 cases occurring in January. In December 1947, a small outbreak of typhus in Osaka was speedily brought under control. In this outbreak 27 cases were reported from one ward of the city between 15 December and 7 January. Control measures were effective and no further cases have been reported from this ward to date.

Research projects now in progress include studies to determine the relationship (if any) between murine and epidemic typhus fever, and the differentiation of types of typhus reported among Japanese nationals, by use of complement-fixation and rickettsial agglutination tests.

The Preventive Vaccination Law passed by the Diet on 1 July 1948 carries a provision for immunization or re-immunization against typhus fever in the event of a threatened epidemic.

--Future Plans--

Typhus control procedures will continue. Dusting programs will be conducted on a year around basis in congested areas of cities, where the louse population density tends to remain consistently high. School children will receive close inspection and dustings as needed, this to continue into the homes of children found infested.

More emphasis will be placed on the DDT treatment of bath houses. Rodent control campaigns will be intensified in an effort to lower the incidence of murine typhus. Control of scrub typhus, in the areas where this form of typhus is endemic, will be attempted.

Research on various phases of typhus fever will continue, specific projects to include: (1) investigation to identify an "undetermined" strain of typhus now present in Japan, (2) continuance of serological studies on serum taken from reported suspect cases of typhus, (3) continuance of work on the relationship which may exist between epidemic and murine typhus fevers, (4) investigations on methods of transmission, (5) evaluation of prepared vaccines against scrub typhus and (6) chemotherapy of the typhus fevers.

Diphtheria

--Introduction--

Diphtheria had been extremely prevalent in Japan at least since 1920. Since 1937, when approximately 28,000 cases were reported, the rate increased each year. In 1944 the number of cases reported was approximately 92,000.

While the Japanese had produced some diphtheria anti-toxin it was used only for treatment and, in some cases, passive immunization. They had never used toxoid for prophylactic immunization. As a result of these circumstances diphtheria was primarily a childrens' disease with 70% of the cases and 90% of the deaths occurring in children 10 years of age and under.

Statistics indicated that for the 7 years preceding 1946 there had always been a peak case and death rate during the months of November or December.

The necessity for a nation-wide immunization program for the children was immediately recognized but the non-availability of toxoid and the inability to produce or procure toxoid made it impossible to conduct necessary immunization of children during the winter season of 1945 and 1946.

Japanese pharmaceutical manufacturing agencies were provided with instructions and the technique for the preparation of diphtheria toxoid and were directed to prepare an amount sufficient to immunize the nations 18,000,000 children of 10 years of age and under. While awaiting production reporting was re-established and preventative measures such as isolation, quarantine and focal immunizations were carried out. This resulted in the number of cases being reduced to approximately 66,000 during the first occupational year. (See chart No. 5).

With production accelerated sufficient diphtheria toxoid was prepared during the spring and summer of 1946 to immunize 18,000,000 children. Plans had been completed for this immunization program to get underway by September. This program resulted in approximately 16,000,000 children receiving immunizations, but the administration had many defects and many of the children did not receive the complete course or the required amount of vaccine. Nevertheless the number of cases during the second occupational year was reduced to approximately 36,000 or a 46% rate reduction as compared to the approximate 66,000 reported during the first year of the occupation. (See chart No. 5).

While the incidence of diphtheria has continued to decline the rate is still too high. A second nation-wide immunization program, that was planned to further reduce diphtheria incidence, has been hampered by difficulties involving production and assay of vaccine. The program has been started and provides for complete immunization (3 inoculations) of all children between the ages of nine months and ten years who have not been previously immunized and a single booster dose for those in this age group, previously vaccinated.

The Preventive Vaccination Law passed by the Diet on 1 July 1948 provides for compulsory immunization against diphtheria for all children between the ages of 6 to 12 months, within six months before entering elementary school and, again, six months before completion of elementary school. The Law further provides for immunization or re-immunization in the case of threatened epidemics.

--Future Plans--

The diphtheria rate has been reduced approximately 70% since the beginning of the occupation. Splendid results have been obtained from control procedures currently being carried out.

The difficulties surrounding production, assay and standarization are being vigorously attacked so the current nation-wide program can be completed with a minimum of delay. Minimum standards and improved assay procedures for diphtheria toxoid will assure better results.

Cholera

--Introduction--

Research revealed there had been little or no cholera in Japan for many years. None was being reported at the beginning of the occupation.

In the spring of 1946, when the repatriation program got underway, cholera did appear on repatriation ships from China and other Far Eastern countries.

--Results Obtained--

Stringent quarantine control measures had previously been initiated and proved to be very effective in preventing cholera entering Japan through the repatriation program. In April 1946 two cases of cholera were reported from the southern island of Kyushu, then isolated outbreaks began to occur which were subsequently traced to illicit shipping and smuggling from Korea, where an epidemic was in progress. Cases continued to increase, totalling 1,229 for the year of 1946, most of which occurred during the months of July and August.

Stringent control measures consisting of isolation, quarantine, disinfection and focal immunizations were carried out in all areas where cholera appeared. These measures were initiated promptly and proved very effective in preventing large scale epidemics. As large areas of the population were immunized wherever cases occurred, particularly seaport cities, approximately 34,500,000 persons received cholera immunizations.

During the second occupation year the cholera rate declined rapidly. Only sporadic cases were reported with the last case occurring in December 1946. Not one single case has been reported since that time, ample supplies of vaccine are on hand for emergency purposes, and quarantine staffs of both Military Government and Japanese prefectural health personnel have been repeatedly cautioned to maintain a close watch for cholera suspects.

The Preventive Vaccination Law passed by the Diet on 1 July 1948 carries a provision for immunization or re-immunization against cholera in the event of a threatened epidemic.

--Future Plans--

This disease has been eradicated from Japan. No immunizations or other active programs are indicated in the absence of reported cases. However, adequate stocks of vaccine will be maintained for emergency use and quarantine personnel have been well orientated on necessary control measures in the event of the appearance of cholera.

Dysentery

--Introduction--

Dysentery has always been prevalent in Japan. This is a filth disease which cannot be eliminated or even satisfactorily controlled until the standards of living, unsanitary customs and practices are improved. Medical science has not as yet provided a satisfactory immunization vaccine, serum or drug capable of controlling this group of diseases. Control therefore lies chiefly in the education of the people in the matter of sanitation, personal hygiene, improvement of water supplies, waste disposal, and the control of flies.

The dysentery incidence has always been extremely high with marked seasonal fluctuations during the year. The peak is reached during the months of August and September with the low point in January or February.

During the past 7 years the rates in August and September have ranged from 200 to 400/100,000 per annum while the low point in January and February ranged from 3 to 15/100,000 per annum. Annual incidence rates have ranged from approximately 70/100,000 per annum to 105/100,000 per annum. Morbidity and mortality rates parallel each other closely.

The poor economic status of the people, plus the complete lack of sanitary conditions as a result of the war and immediate post-war period, resulted in an actual increased incidence of this disease.

--Results Attained--

The dysentery control program involves the improvement of environmental sanitation, water supplies, waste disposal and the control of insects and rodents.

Educational campaigns through the press, radio, posters, schools and social organizations have been fostered.

Sulfanilamides were made available to physicians in addition to the providing of material and supplies for sanitation programs. Training programs for Japanese public health personnel were started.

While these measures did not materially effect the incidence rate during the first occupational year field inspections indicated that sanitary conditions were showing improvement and that a reduction in the dysentery incidence rate could be expected to follow.

During the second occupational year control programs to improve general sanitary conditions were expanded and improved. The number of sanitary teams was increased and were used to control insects and rodents and promote better environmental sanitation conditions.

No marked reduction of the incidence of dysentery occurred during the first half of the second occupational year however, the latter half of the year showed a very substantial reduction as a result of control measures undertaken. (See Chart No. 6).

Dysentery cases continued to decline. During the six month period from August 1947 to March 1948, a 70% reduction in the incidence of dysentery was accomplished as compared to the same period one year ago.

The effectiveness of measures taken in the form of health education, insect control and environmental sanitation is reflected by the fact that the present rate is the lowest in the history of Japan.

One permanent sanitation team has been established for each 12,000 population. These teams are financed, equipped, and trained to carry out all types of sanitary programs.

--Future Plans--

Future programs provide for a continuance of fly control, improvement of environmental sanitation, water supplies, waste disposal and a continuance of the education of Japanese health officials as well as the general public concerning techniques to be used and the importance of such control measures.

Plans have been made for a post-graduate sanitary engineering course which will be established in each of four existing engineering colleges.

Typhoid and Paratyphoid**--Introduction--**

Typhoid is a filth disease and has always been prevalent in Japan. Incidence rates between 1941 and 1946 have varied from 56 to 112/100,000/annum. The morbidity rates have varied from 8.5 to 13/100,000/annum. It is prevalent throughout the year, the highest incidence occurring in July and August.

During the past 7 years the highest reported incidence occurred during the months of August, September and October of 1945, due principally to the destruction and disruption of normal sanitary facilities during the latter part of the war. There was reported during the first year of the occupation, approximately 65,000 cases of typhoid and 11,500 cases of paratyphoid fever. These figures represent a substantial increase over the previous twelve months.

Reports show that of the total number of cases and deaths occurring from typhoid during the first year of the occupation, 43% occurred during the first 3 months or before control measures could be established. This was the period in which the effects of the disruption of normal control measures were most noticeable.

--Results Attained--

Prompt action was taken to improve environmental sanitation and water supplies, to control insects and rodents and establish an immunization program. Since there is an effective vaccine for typhoid and paratyphoid fever it was expected that the incidence of these diseases would be reduced by these measures however, due to the high incidence during the first 3 months of the occupation, the annual rates was adversely effected.

During the first occupational year approximately 20,000,000 persons received immunizations. As the Japanese had no standard procedure for the manufacture and assay of typhoid and paratyphoid fever vaccines the results obtained by immunization were not consistent. The sanitation and immunization programs carried out during this year however, led to a reduction of typhoid and paratyphoid fever cases.

Proof that typhoid and paratyphoid vaccine can be effective against these diseases resulted in a plan for a nation-wide immunization program. In order to insure that this program would be completely successful minimum standards for TAB vaccines were provided, in addition to obtaining cultures successfully used by the United States Army. Difficulties encountered in production and assay were surmounted.

The program was launched in September 1947 and given full publicity. By February 1948 approximately 35,000,000 had received a full course of inoculations.

Control measures during the Occupation have resulted in the disease incidents being reduced from a high mean rate of 82 per 100,000 in 1945 to a mean rate of 23 per 100,000 in 1947, a reduction of 72%.

The Preventive Vaccination Law passed by the Diet on 1 July 1948 requires compulsory immunization or re-immunization against typhoid and paratyphoid fever. Under this law, every person between the ages of 3 years and 60 years will receive an initial immunization, if not previously immunized, with initial immunizations thereafter for every child between the ages of 3 to 4 years after birth and, furthermore, an annual re-immunization of all others between 4 to 60 years of age.

--Future Plans--

The nation-wide immunization program now in progress calls for approximately 60,000,000 people to receive immunizations. This program is about 55% complete and will be closely followed to permit completion at an early date.

In 1949 it is planned to give booster doses, on or about 1 May of each year, to those having previously completed the full course of inoculations.

Long range plans have been drawn up for the continuance and improvement of sanitation programs. These control measures will further reduce typhoid and paratyphoid fever to levels comparable to other modern nations.

Malaria

--Introduction--

Malaria has been endemic in certain areas in Japan for many years but its extent is not known as it was not a reportable disease until June of 1946.

For the 12 month period, September 1946 to August 1947, the reported incidence was 24.0/100,000/annum, this rate including primary and recurring cases.

The greater majority of cases were recurrences occurring in demobilized military personnel repatriated from the Southwest Pacific area and the Asiatic mainland. There was also considerable malaria in civilian repatriates from China, Manchuria and Southeast Asia.

--Results Attained--

Sanitary teams were established throughout the nation with insect control as a major activity in the endemic areas. Adequate supplies of insecticides and larvacides were provided in addition to establishing malaria control training courses.

There has been a progressive decline in the number of cases reported since near completion of repatriates from the above-named repatriation areas and also the decrease in the number of recurrences in infected repatriates.

A three months course for sanitarians was established in the Institute of Public Health in Tokyo. Five such courses have been completed by selected Japanese personnel representing each prefecture in Japan. These individuals are carrying out similar teaching activities in their own prefectures.

--Future Plans--

The program to establish one six-man sanitary team for each 13,000 population is being pushed to completion. These teams will be active on a year-around basis and included in their education will be full instructions on malaria control. They will be responsible for malaria control activities in areas where the disease is prevalent or endemic.

Education of the general public in malaria control will also be accentuated.

Japanese B. Encephalitis--Introduction--

Japanese B. Encephalitis has been present in Japan for many years with occasional epidemics having been reported. The last two major outbreaks occurred in 1924 and 1935. The disease was made reportable in June 1946. The incidence for clinical and suspected cases from September 1946 to August 1947 was 0.2/100,000/ annum; from September 1947 to February 1948 - 0.5/100,000/annum. The majority of these cases however, were not confirmed by laboratory examinations. Okayama prefecture where the disease is most prevalent had the highest incidence rate.

--Results Attained--

Studies designed to evaluate the effectiveness of Japanese B. Encephalitis vaccine among the Japanese people were undertaken during the early summer months of 1946 and again in 1947 in Okayama prefecture.

Due to the paucity of cases however, no conclusion could be reached although it was noted that no cases were reported among vaccinated individuals.

Insect control programs have been carried out in all areas where the disease has occurred.

Special studies are continuing to determine anti-body levels in selected groups of vaccinated and non-vaccinated children. From the studies it is expected that final conclusions can be made on the effectiveness of immunization programs.

There have been no epidemics of Japanese B. Encephalitis since the occupation.

--Future Plans--

Future plans provide for a continuance of the special studies currently being conducted.

Scarlet Fever--Introduction--

Scarlet Fever has existed in Japan at least since 1897 when it was made a reportable disease. Available records indicate that 1939 was the peak year when the rate was 28.3/100,000/annum. In 1946 the incidence was 2.9/100,000/annum and although the rate rose to 3.4 during the early part of 1947, it has again decreased to 3.2.

--Results Attained--

The incidence of scarlet fever was declining progressively and as it has not constituted a serious public health hazard at any time during the occupation no specific action or program was attempted other than to maintain sound practices of isolation of cases and observation of families and contacts.

--Future Plans--

It is planned that the application of quarantine therapy, using penicillin and/or sulfonamide as treatment, will serve not only to reduce the death rate but will also shorten the period of infectiousness and aid in the reduction of morbidity.

Epidemic Meningitis

--Introduction--

Epidemic meningitis has been a reportable disease in Japan since 1918. It has remained at a consistently low level.

Prior to the occupation the highest incidence recorded was in 1939, 2.3/100,000/annum and although the rate rose to 6.3/100,000/annum in 1945, it has again dropped to its' pre-war level, and for the past six months has remained at 2.2/100,000/annum.

--Results Attained--

The disease has not constituted a serious public health hazard since the occupation therefore no specific action has been taken other than to adopt isolation techniques and observation of families and contacts.

--Future Plans--

It is planned to use penicillin and/or sulfonamide in the treatment of epidemic meningitis cases which is expected to decrease the death rate and shorten the period of infectiousness, thus aiding in the reduction of morbidity. Improvements in hospital care is also expected to lower the disease incidence.

Pertussis

--Introduction--

Pertussis is very prevalent throughout Japan and a major cause of deaths among infants and young children. It was made a reportable disease in March 1947.

The incident rate for the six months period (September 1947 to February 1948) was 73.1/100,000/annum.

--Results Attained--

Due to the necessity of confining efforts to the control of the diseases which were a more serious public health hazard, no action was taken to initiate a program for reducing the incidence of pertussis until near the end of the second occupational year. Production of pertussin vaccine and assay standards has been encouraged and plans for the vaccination of all infants and small children have been completed.

Under the provisions of the Preventive Vaccination Law passed by the Diet on 1 July 1948, immunization of all infants against pertussis will

become compulsory by 30 June 1949. The law provides for immunization of all infants between 3 to 6 months after birth and re-immunization 12 to 18 months after the initial immunization. The deferment of full enforcement of the law until 30 June 1949 was necessary because current production facilities were not adequate for immediately producing the required amounts of vaccine. However, production is showing rapid increases and immunizations of all infants and small children are continuing as fast as vaccine is produced and assayed.

--Future Plans--

Future plans provide for close follow-up of vaccine production so that sufficient quantities will be available to carry out the planned immunization program on all infants and small children. This program, plus general health education, is expected to reduce the current disease rate.

Tuberculosis

--Introduction--

Tuberculosis has always been extremely prevalent in Japan. Accurate figures on morbidity have never been available, although deaths have been reported since 1900. Prior to the occupation, tuberculosis was not a reportable disease.

Under the best of conditions statistical reporting on morbidity of tuberculosis is of little value. Studies on tuberculosis have in the past in all areas therefore relied on mortality statistics in order to obtain comparative results.

In 1900 statistics indicate the death rate in Japan was 160/100,000/annum. This rate gradually increased until 1918 when it was recorded at 250/100,000/annum. A gradual decline then took place and in 1932 had dropped to 170/100,000/annum. Since then, there had been another steady increase and in 1945, upon arrival of the Occupation Forces, the rate was 280/100,000/annum.

Tuberculosis has been the leading cause of death in Japan since 1930 and accounts for 12 to 14% of the deaths from all causes. The rate is among the highest in the world. As it was considered a shameful disease, to be concealed whenever possible, very few cases were brought to the attention of medical authorities.

The serious economic conditions, lack of food, fuel and clothing, overcrowding and unsanitary conditions during the last years of the war have contributed materially to the continued prevalence of this disease. Tuberculosis sanatoria were found in 1945 to be only 25% occupied, mainly due to active cases leaving these institutions to seek food, and who were then acting as sources of additional infections.

It is estimated that there are ten active cases of tuberculosis to every death. Based on reported deaths, 153,000 in 1940, which increased to 200,000 in 1945, Japan was estimated to have approximately 2,000,000 active cases.

Japanese had been conducting research on BCG since 1937 and in 1943 the National Research Council had evaluated the progress made up to that time and concluded that the use of BCG vaccine should be encouraged as a means of tuberculosis control. In 1944, 5,025,794 individuals between the ages of 10 and 19 years had been immunized with BCG, provided they were negative to tuberculin tests. In 1945, 3,098,444 individuals between the ages of 15 and 24 years were inoculated. BCG vaccine used was of questionable potency in many cases due to lack of standardized assay procedures.

--Results Attained--

During the first year of the occupation, the urgency of establishing health control measures for the more acute communicable diseases resulted in tuberculosis control not receiving major attention.

It was not until October 1946 that an active control program was inaugurated in which the immediate objectives may be summarized under five headings:

1. To encourage the return of active cases of pulmonary tuberculosis to hospitals by providing necessary food supplies and enabling hospitals to care for these patients.
2. Emphasis upon education of the medical and nursing professions in diagnosis, treatment and care.
3. The inauguration of a school lunch program for supplemental feeding of school children to provide a more balanced diet and increased resistance to infection.
4. The mass examination of school children together with individual case finding, tuberculin testing and BCG immunizations.
5. Mass examination of workers in factories and other industrial organizations.

Full publicity was given this program through all media of information, radio, press, posters and lay and professional journals and magazines. Many prefectures organized Tuberculosis Care Committees whose primary function is to assist patients in entering sanatoria, maintenance of their families during hospitalization and obtaining suitable occupations upon their return from the sanatoria.

Significant results were immediately noticeable (See Chart No. 8). Through increased government rations to hospitals and institutions, augmented by voluntary contributions through LARA, (Licensed Agency for Relief in Asia) the food situation has improved and all prefectures are receiving increased diets for tuberculosis patients. A school lunch program was successfully inaugurated and has been expanded to now serve approximately 5 million children. (See Chapter 6, Welfare, The School Lunch Program).

X-ray equipment was furnished by rebuilding old units, also by manufacturing new equipment, and sufficient film was produced to meet requirements.

Case reporting was required in January 1947 and represents the first time that tuberculosis has ever been reported in Japan. These reports indicated that tuberculosis was occurring at the rate of approximately 420,000 cases per year.

The nation-wide examination program for the detection and control of tuberculosis has been vigorously followed. Mass examinations have taken place in many factories, schools and other organizations. The vaccination program was encouraged and approximately 23,000,000 individuals have received BCG immunizations to date.

Education of the medical and nursing professions, in addition to the education of those individuals having active cases, has resulted in an increased hospital occupancy and tuberculosis sanatoria now report an average of 25,000 occupied beds each month.

Many conferences were held with selected lay and professional groups in various prefectures in Japan for the primary purpose of stimulating interest in and educating these individuals in tuberculosis control. Emphasis was placed upon the importance of coordination between the national, prefectural and local agencies in control activities. Results of this activity was reflected in an increase in tuberculin tests and BCG inoculations, in addition to an increase in the number of hospital patients.

The control program has resulted in a reduction in death rate from 280/100,000/annum in 1945 to 189/100,000/annum in 1947. Study of the deaths by age groups indicates that the entire reduction has occurred in the age groups immunized with BCG. The death rate in non-immunized groups has not been reduced during this period. The reduction in the death rate from 280 to 189 represents the weighted average of both non-immunized and immunized age groups, covering the total population of Japan.

Within the immunized age groups the morbidity has been reduced by 79% and mortality by 90%. (See Chart No. 8a).

--Future Plans--

It is proposed to expand and amplify the current programs, extending immunizations with BCG from 6 months to 30 years. The procedure to be followed is to tuberculin-test all individuals, within the age groups stated above. Those who show positive tests are examined for evidence of clinical tuberculosis, this examination including x-ray on 35 mm. film. Suspicious cases are re-x-rayed on full-size film and complete physical examinations, including sputum sedimentation rates determined. Active clinical cases thus found are placed under treatment and careful follow-ups on contacts are carried out.

Tuberculosis negative cases are immunized with BCG and will be tested annually. Those who have lost immunity as indicated by these tests will be given booster doses.

Due to lack of refrigeration facilities in Japan, particularly in rural areas, the potency of liquid BCG vaccine is approximately 7 days. The present program involves the production of sufficient dried vaccine to meet all requirements in two laboratories which can receive close supervision and control in maintaining adequate assay standards. It is expected that 30,000,000 additional individuals in the new age groups will have been immunized by 1 July 1949.

Venereal Disease

--Introduction--

Preliminary studies and observations of the venereal disease problem at the beginning of the occupation revealed the following information:

1. Venereal diseases were considered as diseases of prostitutes, primarily, and for this reason were never a cause for concern either by the Japanese physicians or the general population.
2. Japanese physicians, with very few exceptions, were unfamiliar with the epidemiologic and clinical manifestations of venereal diseases.

3. Control methods were almost entirely devoted to the periodic examination of prostitutes and such examinations as were made, were perfunctory and practically worthless.
4. No provisions existed for the care of infected persons in the general population.
5. Such clinical procedures as were in effect were archaic; laboratory procedures were poor and totally inadequate.
6. Contact tracing was not done.
7. Venereal diseases were not reportable and consequently no statistics were available as to the extent of venereal diseases or as to the incidence of the venereal diseases.
8. Licensed prostitution was legal and flourished both in brothels and on the streets, so that the opportunity for the spread of venereal diseases was practically unlimited.
9. Segregation of prostitutes into prostitute districts, which was said to be strict before the war, had broken down during the war years.
10. Permits to work as prostitutes were formerly under police supervision but this also became lax during the war.

--Results Attained--

Faced with the realization that the venereal diseases posed as a serious problem to the Occupation Forces the Japanese Government was directed by SCAPIN 153, dated 16 October 1945, to:

1. Designate syphilis, gonorrhea and chancroid as infectious diseases.
2. Report all syphilis, gonorrhea and chancroid on a basis similar to that in effect for reporting other notifiable diseases.
3. Rigid enforcement of laws for the prevention of infectious diseases and all laws, ordinances, regulations and instructions issued thereunder and which relate, directly or indirectly, to the prevention and treatment of venereal diseases.
4. Bring under examination, treatment and provision of these laws, ordinances, regulations and instructions, all individuals whose occupation or activities subject them to serious hazard of venereal disease transmission.
5. Provision of hospitals, clinics and laboratory facilities, personnel, equipment and drugs necessary to insure required examinations, isolation, hospitalization and treatment.
6. The establishment of minimum technical and administrative standards and procedures for the guidance of operating agencies in connection with all phases of this program.

A subsequent instruction SCAPIN 642, dated 21 January 1946, further directed the Japanese Government to abrogate and annul all laws, ordinances and other enactments which directly or indirectly authorize or permit the existence of licensed prostitution in Japan and to nullify all contracts and agreements which have for their object the binding or committing, directly or indirectly, of any woman into the practice of prostitution.

Reporting started in December 1945 and although the system was new to Japanese personnel the number of cases reported gradually increased each month as physicians became familiar with venereal disease and the machinery for reporting was improved. During 1946, 128,845 cases of gonorrhea, 74,609 of syphilis and 30,974 of chancroid were reported.

The increase in the number of cases reported does not necessarily indicate that venereal disease incidence has increased and is primarily attributed to advancements made in educating the Japanese doctor, as well as the general public, in proper methods of venereal disease control.

Continuous efforts have been made to improve professional techniques, to provide improved hospital and clinic facilities for venereal disease patients, and to educate both the medical profession and the general population in the medical aspects of these diseases.

Treatment facilities for the general population have been established in many national, prefectural and municipal hospitals, health centers and clinics. Treatment schedules have been furnished, and clinical and epidemiologic procedures have been demonstrated.

A prepared manual on the principles of venereal disease control has been translated into Japanese and distributed.

Effective drugs such as the sulfonamides, mapharsen, bismuth subsalicylate and penicillin are being produced from indigenous Japanese sources, augmented by imports when supplies prove inadequate. With the exception of sulfonamides none of these were produced in Japan prior to the occupation. Action has also been taken to supply adequate food to hospitals treating venereal diseases to insure the retaining of VD patients as long as necessary.

Japanese prefectural venereal disease control personnel have been designated in each prefecture and under the supervision of Military Government Health Officers have been directed to place special emphasis upon venereal disease control in the general population.

Special lectures and training in venereal disease control is now included in full time and short refresher courses for doctors, public health nurses, internes and medical students.

The overall program has been given wide publicity and in conjunction with the Civil Information and Education Section of SCAP, information is being disseminated over the radio, through the press, magazines, journals, and by poster displays to the general public.

The new Health Center Law (Law 101, 5 September 1947 - Refer Section III, Chapter 1) provides for a venereal disease control service in each of the planned 780 health centers throughout Japan. Currently, there are 180 VD clinics in the 675 health centers now in existence. During the model health center demonstration recently held in Tokyo a model health center venereal disease control service was demonstrated for the guidance of Military Government and Japanese prefectural health officers. Besides the operation of a clinic, such other functions as contact-tracing, case holding, routine serological tests, mass blood-testing and public education were stressed.

In addition to the VD clinics in the health centers there are approximately 424 other diagnostic and treatment clinics in operation.

The Ministry of Welfare is supporting the venereal disease program and is providing leadership, funds and facilities for its support and expansion. For example, some patients found the cost of medical care prohibitive and in order to meet this situation a plan was developed whereby the national and prefectural governments share equally the cost of treatment thereby assuring prompt and complete medical attention for medically indigent Venereal Disease cases.

During the past six months period, 107,724 cases of gonorrhea, 84,410 of syphilis and 20,271 of chancroid were reported. Since venereal disease control is a new project in Japan the reporting of cases by private physicians is not, as yet, 100% satisfactory. Because of this fact, it is not possible to show clear-cut progress in the form of statistical data. However, definite progress is being made evidenced by the interest of both lay and professional people in advancing the over-all control program. (See Chart No. 9).

Venereal disease control is a combined operation requiring the cooperation of police, courts, welfare and detention agencies and medical service. As these agencies learn to improve their services to the people, venereal disease control in Japan will continue to improve. It will take several years under existing conditions before an entirely satisfactory program can be evolved and improvement demonstrated statistically.

A Venereal Disease Prevention Law passed by the Diet on 3 July 1948 becomes effective on 1 September 1948. This law provides for pre-marital examination for venereal disease, a pre-natal examination for venereal disease and compulsory examination of all contacts and suspects. Civil rights are safe-guarded in the case of all compulsory examination by provisions for appeal to a court by the individual, if he claims there is not reasonable evidence to suspect the presence of venereal disease. The law further provides for free treatment for all venereal disease patients who are unable to pay for such services.

--Future Plans--

Future plans provide for the establishment of a satisfactory diagnostic and treatment clinic in every health center in Japan. Efforts will also be directed towards continuance and expansion of the present program with special emphasis on education and improved reporting procedures. Acceleration of Japanese indigenous production of venereal drugs is also planned.

Reduction in Death Rates

The overall success of the various communicable disease control programs is demonstrated by the fact that the mean crude death rate for the first five months of 1948 was 13.3 per 1,000 per annum as against 16.8 per 1,000 per annum for the corresponding period in 1947 and 28.4 per 1,000 per annum for the corresponding period in 1945. The 1948 figure is 21% less than 1947 and 53% less than 1945.

Vital Statistics and Morbidity

Introduction

The vital and public health statistics facilities of the Japanese Government were never adequate in meeting the public health needs. During the war years they had practically ceased functioning and, in August 1945

due to transmission difficulties, the submission of scheduled reports of births, deaths, stillbirths, marriages and divorces had been ordered stopped by government officials.

Only simple numeric reports of events were being submitted and these were long delayed. Quarterly vital statistics reports were discontinued in 1938 and the last annual report was published in 1943. No current vital statistics reports were prepared.

Morbidity registrations were long delayed and the list of diseases being reported was too incomplete to meet public health requirements. Reports included diphtheria, dysentery, typhoid, para-typhoid, smallpox, typhus fever, scarlet fever, epidemic meningitis, cholera and plague which were submitted every ten days, by prefecture. Provisions also included requirements for monthly reports by prefecture, however, this information was not being furnished although annual reports were published until 1942.

The end of the war found the nation virtually uninformed at the national level regarding such vital data and, in many cases, at prefectural and local levels.

Reorganizing Reporting Procedures

In September 1945 a basic directive, SCAPIN 48, was issued to the Japanese Government concerning its responsibility for the public health, including vital statistics. Starting with the week ending 20 October 1945, current morbidity statistics have been compiled and published regularly in the Weekly Bulletin of the Public Health and Welfare Section.

Chancroid, gonorrhea and syphilis were made reportable diseases in October 1945.

In May 1946 a second directive, SCAPIN 945, was issued which set forth vital statistics as a responsibility of the prefectural health offices. This same month, a Division of Vital Statistics (since changed to Health Statistics Division) was organized in the Public Health and Welfare Section.

Japanese "B" encephalitis and malaria became reportable diseases this same month.

As a temporary measure, the Cabinet Bureau of Statistics was directed to reinstate its previous practice of obtaining partial transcripts of the data contained on the original registrations and to prepare monthly statistical reports by prefecture. The first step was begun in July 1946 in the preparation of reports by the Koseki Offices (Local Registration Office) on the number of births, deaths, stillbirths, marriages and divorces.

The registration of vital events under the Koseki Offices (Local Registration Office) was primarily for the purpose of maintaining civil registration, rather than to meet the statistical requirements of modern public health practices. This was recognized at an early date. In the interim, plans were formulated to expand and reorganize the vital and public health statistics to provide for administration of public health based on factual data.

In September 1946, the designs of both the schedule and declaration forms of the vital statistics were completed and on 1 October, all offices began using the new forms, with the exception of stillbirths. Stillbirth laws were amended in November to require stillbirth declaration and the declaration form, which included the medical certification, was placed in use the same month.

Current monthly reports were published by the Cabinet Bureau of Statistics for the first time in December, on the basis of scheduled reports, including specific causes of death.

The 1928 International List of Causes of Death, as adopted by Japan in 1933, was revised in December 1946. The normal revision of 1938 was not carried out because of war activities. In January 1947, the Manual of Joint Causes of Death, used by the United States for the selection of joint causes of death, was adopted with slight modifications and translated into Japanese.

The Committee on the revision of the international list of causes of death met in a conference on 5 July 1948 to study the preliminary report prepared by the Interim International Committee in Geneva, Switzerland. Several of the recommendations which the Japanese Committee had submitted in 1947 for consideration were adopted in the report.

The Public Health Statistics Section

The compilation of public health statistics was originally the responsibility of two government agencies. The Cabinet Bureau of Statistics, of the Bureau of Census furnished information on the vital statistics; the Investigation Section in the Ministry of Welfare furnished information on morbidity statistics.

To meet the statistical requirements of modern public health practices, it was realized the competent Ministry for the administration of the public health should be responsible for all public health statistics administration. A plan was adopted to organize a Public Health Statistics Section in the Ministry of Welfare. This reorganization, of necessity, proceeded rather slowly due to the need for continuing all statistical reporting during this transitory period.

On 1 August 1947, the new Public Health Statistics Section was officially established and was made responsible for preparing morbidity and other public health statistics. On 1 September, the Section further assumed all responsibility for the vital statistics.

In July 1948 a reorganization of the Ministry of Welfare resulted in this section being raised to department status and becoming known as the Health Statistics Department. It is divided into three sections; a Field Staff Section, a Tabulation Section and an Analysis and Reports Section. As now constituted, the Health Statistics Department provides the necessary statistical facilities to meet the public health needs of the nation.

Development of the Program

Paralleling the final organization of the Health Statistics Department, several methods for testing the completeness of registrations were reviewed during the first four months of 1947. With the assistance of the Advisory Committee to the Justice Ministry on Vital Registrations in the Koseki offices (Local Registration Office), these methods were tested in the cities of Kure, Hiroshima, Oniya, Fujisawa, Chiba and in two wards in Tokyo.

From these studies came the adoption of a uniform nation-wide method of checking the completeness of registration. Under these procedures, attendants are required to report the occurrence of births and deaths to the Koseki offices and stillbirths to local health offices. This has served to stimulate more complete registration. Data for July 1947 indicated a completeness of 96.0% for births and 98.7% for deaths.

In January 1947, the addition of 13 reportable diseases (measles, pertussis, tuberculosis, pneumonia, influenza, anthrax, glanders,

leprosy, puerperal infection, rabies, tetanus, trachoma, yellow fever) to the official list being reported, furnished more complete coverage on communicable disease control.

In April, an Advisory Committee on Public Health Statistics was organized to serve the Ministry of Welfare. They have furnished several noteworthy reports; such as, the use of control charts for communicable disease statistics, the cost of medical treatment and care, and the computation of infant and stillbirth rates.

In April 1947, the Institute of Public Health introduced a two week training period in public health statistics as part of the four-month refresher course for public health nurses. In June, public health statistics training comprised a part of the refresher courses for the chiefs of Japanese prefectural health offices and health centers. This training has been expanded and is now included in refresher courses for pharmacists, veterinarians, sanitarians and nutritionists. Refresher courses, in the various fields mentioned above, are continuing.

In April 1947, the weekly morbidity report of the Public Health and Welfare Section was expanded to include tuberculosis, measles, whooping cough and pneumonia. Influenza was added in May.

June 1947 saw the development and adoption of a plan whereby the registration of the new born for the issuance of rations is premised upon presentation of evidence that the birth has been properly registered in the local registration office. Registrations have been more prompt since this procedure was introduced.

The Ministry of Welfare, although required by SCAP to submit weekly morbidity reports from the beginning of the Occupation, had never published current reports for use by the prefectural and local health offices. In June 1947, the Ministry was directed to start the submission of such reports, which included the number of cases for each disease reported according to prefecture, together with a brief analytical statement. The first report rendered was for the week ending 31 May.

After several conferences, a plan to aid attending physicians and midwives reporting births, attended by them, to local government offices, resulted in a "free postcard" system being placed in operation on 1 July, through the cooperation of the Ministries of Welfare, Communication and Justice. Similarly, in cooperation with the Ministries of Welfare and Communications, a "free postcard" system was developed to aid the reporting of communicable diseases by the attending physicians. This was also placed in operation on 1 July.

Likewise in July, the Ministry of Welfare completed the design of a series of four epidemiological forms to be maintained in the local health centers. Separate record forms were provided for tuberculosis and venereal disease. A group card was designed for the intestinal diseases, and another card for the rest of the diseases reportable to the Ministry.

In August 1947, a plan was adopted resulting in approximately 72 field workers (physicians) being attached to the prefectural health offices, and whose duties were to assist in obtaining as complete and accurate registrations of births, deaths and stillbirths, as possible, particularly better medical certifications. In addition, the 287 chiefs and assistant chiefs of the prefectural Justice Department offices were to render assistance in general registration problems.

During this month the Ministry of Justice published a manual on registration procedures and distributed copies to all prefectural Justice Department offices. The Cabinet Bureau of Statistics also published a manual concerning the preparation and forwarding of the schedule forms, and the Ministry of Welfare completed the writing of a comprehensive manual for physicians on public health statistics.

Poliomyelitis was made a reportable disease in August 1947.

During the past six months period several national and regional conferences were held to solve practical problems concerning the registration of births, deaths, stillbirths, marriages and divorces. Conferences were likewise held to solve problems on the reporting of morbidity statistics. These conferences attended by Japanese national, prefecture and local personnel have resulted in increased efficiency in registration and reporting procedures.

Budget fund allocations were provided to establish a Public Health Statistics Unit in each planned health center in Japan. During the model health center demonstration in Tokyo, visual and practical work on the operation of a statistical unit was demonstrated.

During October and November 1947, following a series of conferences, vital statistics responsibilities of the prefectural statistical offices were transferred to the prefectural Public Health Department and at the same time, instructions were issued by the Ministry of Welfare to establish public health statistical units in each prefectural Public Health Department. By the end of November, these units were in operation in all 46 prefectures in Japan.

During November a comparative study, of International List titles of causes of deaths, was prepared on four Japanese Lists published between 1920 and 1947, to facilitate historic studies of specific causes of death. This same month, basic historic tabulations of numbers and the calculation of rates for births, deaths, infant deaths, stillbirths, marriages and divorces by prefectures numbers and rates for all Japan by month, and numbers and rates for selected causes of death for all Japan, for the period 1920 to 1947, were completed.

The National Committee on the Cost of Medical Care of the Ministry of Welfare conducted a survey during November and December of 1947 to determine the cost of operating medical institutions and the fees charged by medical practitioners. Data from this survey, which was conducted in 18 prefectures, and included damaged and undamaged war areas, is expected to be tabulated and completed in August 1948.

As a result of furthering the training of public health statistical personnel, the completeness of birth registrations increased from 96.0% in July to 97.5% in October, and the completeness of death registrations increased from 98.7% to 99.1% during this same period.

In December, all vital statistics activities of the former Advisory Committee on Vital Statistics to the Cabinet Bureau of Statistics were transferred to the Advisory Committee on Public Health Statistics to the Ministry of Welfare and 18 sub-committees were subsequently formed.

Effective 1 January 1948, the National Family Registration Law (Koseki-Ho) and the Civil Laws were revised to bring them into conformity with the new constitution of Japan. At the same time, declaration forms of the vital statistics were revised by the Ministry of Justice in order to meet the requirements of the revised civil and family registration laws. For the first time in the history of Japan, a medical certification was adopted as a part of the revised "declaration of live birth forms" by the

Ministry of Justice. Schedule forms of births, deaths, stillbirths, marriages and divorces were revised to correspond with the revision in the new declaration forms and became effective on 1 January 1948. (See Charts Nos. 10-11-12-13-14-15).

January 1948 also observed a change in the routing of the schedules of births, deaths, stillbirths, marriages and divorces in which forms from the local Koseki (Local Registration Office) were routed through the health centers, to the Public Health Statistical Unit of the prefectural Public Health Department. At the same time, responsibility for the preparation of the monthly numeric reports of the vital statistics was transferred from the Koseki Offices to the health centers. The next monthly report showed no delay resulting from this change in procedure.

During January and February the Ministry of Welfare conducted a training conference in each of the nine regional areas in Japan, which was attended by statistical employees of the health centers, the prefectural Public Health Departments and members of the field staffs of both the Ministries of Welfare and Justice.

In addition to the development of a modern public health statistical program, the Health Statistics Division of the Public Health and Welfare Section has compiled several special statistical reports, notably; the report for the Harrison Food Mission to Japan (February 1947), the Statistical Report for the Ekiri Mission to Japan (May - August 1947), and a historical tabulation of the number of cases and deaths of communicable diseases for all Japan by months and years for the period 1920 - 1947, which included current rate tables.

Future Programs

The most important objective is the continued training of morbidity, vital and other public health statistics personnel as a means of increasing the efficiency and promptness of reporting and registration procedures. This will be accomplished by refresher courses, conferences, and on-the-job training.

Future programs also include a plan to increase the field staffs of both the Ministries of Welfare and Justice. They form an important part of the educational program for public health statistics.

The Ministry of Welfare lacks mechanical tabulating machine equipment for compiling public health statistics data. Efforts will be made to obtain the necessary equipment.

Under consideration is the applying of photographic techniques in the transcription of statistical data for transmission to the Ministry of Welfare. Microfilm records are much easier to transport and require less filing space.

Epidemiological case cards, which were designed in July 1947, will be prepared in all health centers beginning approximately 1 June 1948. Due to budget limitations, they will, at first, be limited to the legal diseases, however, it is anticipated that an increased budget allocation will provide sufficient personnel to permit case card preparation for all reported diseases. Part of this data will be transcribed onto schedule forms to be forwarded to the Ministry of Welfare (Public Health Statistics Section) for tabulation and analysis.

Due to changes in declaration forms, Koseki and civil laws, and routing of vital statistics and morbidity reports, the manual for physicians, on public health statistics, will be rewritten.

SanitationIntroduction

Sanitation in Japan was a combination of both modern and medieval practices. The larger cities, such as Tokyo, Yokohama, Kyoto and Osaka had some adequate waterworks and sewerage and waste disposal systems, but they were in need of considerable repair as a result of deterioration and war damage.

Due to the rigid economy forced on the people by a totalitarian state, strange and peculiar living habits were adopted, many of which have remained unchanged for centuries. Public bathing, working and living intimately together in overcrowded facilities and homes, utilization of waste material, lack of adequate agencies to properly administer sanitation problems, plus the ancient oriental philosophy of making the individual responsible for his existence, retarded the adoption of modern sanitary practices.

A poorly conceived tax rate and a confused system of administering public finances, necessitated local communities pooling their resources together to finance basic sanitation operations. This resulted in the formation of local sanitary associations, known as Eisei Kumiai, which consisted of a group of residents who were compelled to contribute to a fund conducting community sanitary affairs. Their activities consisted chiefly of handling contracts for the collection of night soil and garbage, immunizations, and street and sewer cleaning.

These local associations were subsequently formed into a national federation which was used by the Government as the official agency in dealing with the people on sanitary matters. During the war, they were taken over by the Tonari Gumi, a national war-time agency comprised of small local neighborhood associations. The chiefs of each Tonari Gumi had direct control over the individual in such matters as rations, purchase of war bonds, sanitation, fire fighting, air raid plans and forced labor. Both associations have now been dissolved.

Prior to the occupation, sanitary inspections were a function of the Police Department. Private premises were inspected periodically, inspectors being mostly interested in the general policing of homes and premises rather than public health hazards.

The installation of water works was carried out under the supervision and guidance of the Streams and Rivers Section of the Home Ministry. After completion, they were turned over to the local water works bureau who had the responsibility for their operation and maintenance. Only in cases where outbreaks of diseases occurred, that were clearly traceable to the water supply, was the Health Department called in and then only to advise on proper methods of sterilization. The revenue derived from water taxes was very small and inadequate to provide for proper maintenance. Chlorination of water supplies was performed only when it was known to contain harmful bacterial contamination. Personnel operating the water plants usually inherited the job and received very little or no formal training.

Sewers, drains and sewerage systems were the responsibility of the Public Works Section of the Home Ministry during planning and construction stages, and upon completion were turned over to local agencies for maintenance and repair. These agencies were also left without provisions for financial operations. An attempt was made to pass on to the individual this responsibility, by putting provisions in the "Foul Matter Law", requiring the individual to maintain the section of open drainage ditches adjacent to his property without making provision for overall maintenance of the entire system.

The disposal of night soil and domestic wastes was likewise a responsibility of the individual, actual collection usually being made by contractors or farmers. Very little improvement has been made in methods of collecting and utilizing night soil since ancient times. The dry pail method of collection, and disposal by using as a fertilizer, was the system being universally employed throughout Japan. Insect and rodent control as a separate community endeavor was not known in Japan except as it affected agricultural pursuits.

The ravages of war had drastically depleted the already meager supplies of material, equipment, and facilities for carrying on sanitary operations. The loss of approximately 50% of the housing facilities of the major cities had resulted in the crowding together of masses of people in railroad stations, tunnels, public buildings, etc., many of which had no sanitary facilities whatsoever. Large movements of the population, particularly refugees and repatriates, brought many susceptible people into contact with diseases to which no immunity had been acquired.

Organization of Sanitary Teams

Recognizing the immediate need of improving general sanitary conditions, efforts were first directed to the clearing and removal of debris resulting from the war, the repairing of damaged water supply systems and to generally improve environmental sanitation. Meager stocks of medical and sanitary supplies were obtained from confiscated Japanese Army-Navy and surplus U.S. military stocks which were distributed on the basis of greatest need. Six man sanitary teams were then organized and used for typhus control, their activities consisting chiefly of eliminating the louse population. Under the supervision of occupation force personnel, the training of these teams was extended, during the spring of 1946, to include insect and rodent control. Training schools were conducted at Kyoto and Sendai for the benefit of Japanese personnel working in these sanitary teams, and later a training school was conducted in each of the nine regions in Japan.

Due to limited amounts of insecticides, equipment and funds, operations during the early part of the first occupational year were largely limited to epidemic disease control. However, before the end of the year, 9,000 teams, employing 54,000 personnel were actively engaged in insect and rodent control activities.

During the formation of the sanitary teams, steps had been taken to provide sufficient supplies of insecticides, rodenticides, and other sanitary supplies and equipment. At the beginning of the second occupational year, funds were provided in the Ministry of Welfare budget for expanding the activities of these teams.

The Ministry of Welfare budget for the fiscal year beginning 1 April 1948 provided a budget for one sanitary team to each 13,000 population, aggregating approximately 6150 such teams. The National Government subsidizes 50% of the labor cost to prefectural governments, and matches one-third of the equipment and supply cost against the prefectural governments' two-thirds. These teams are on a permanent basis and can be augmented by volunteer teams at the local level in case of a threatened epidemic.

Insect and Rodent Control

Insect and rodent control activities, as carried out by the sanitary teams, has made steady progress since the beginning of the occupation. At first handicapped by lack of supplies and equipment, production by Japanese manufacturers using imported DDT concentrate, resulted in 6,000,000 pounds of 10% DDT dust; 1,000,000 gallons of 5% DDT residual effect spray; 650,000 gallons of 30x pyrethrum concentrate emulsion and 120 tons of Antu (rat poison) becoming available during the second occupational year.

In addition to the above supplies, large quantities of powered and manual operated dusting and spraying equipment were produced. Ample stocks of both supplies and equipment are on hand to meet all requirements.

Insect and rodent control activities center around the spraying and dusting of streams, pools, basins and other types of areas that are apt to be a breeding place for flies and mosquitoes during the spring and summer seasons. Activities also include louse and flea control, involving the dusting or spraying of homes surrounding the area where a case of typhus, or other communicable diseases caused by lice or fleas, has occurred and which oftentimes includes the dusting and spraying of entire villages.

Baiting and trapping of rodents is another activity, this being conducted on a year-round basis. Japan has an exceedingly large rat population, therefore extensive efforts are being made to eliminate this rodent through the use of Antu (rat poison) and traps.

For centuries, Japanese people have believed that rats, harboring in their homes was a good omen, and it has taken consistent efforts to prove the rat is hazardous to human health.

Various ingenious methods have been developed to kill the rat population. The most successful is to bait and trap large areas, such as several city blocks or an entire village, combining this with the DDT dusting or spraying of all harborages and passageways prior to baiting. This has produced good results and has definitely aided in reducing louse and flea-borne disease incidence.

Insect and rodent control is a continuing program. Constant supervision is being given to improve and expand such activities, and to further the training of control personnel.

Water, Sewerage and Waste Disposal

Due to the scarcity of materials and lack of adequate funds, the rehabilitation of water works plants was initially confined to those installations serving the Occupation Forces. These systems also serve the Japanese people in the area. Water from these sources is purified and chlorinated according to U.S. Army standards.

Considerable quantities of imported chlorinating materials were necessary until such supplies could be produced from Japanese indigenous sources. The nation is now meeting all requirements.

Not all water works plants use chlorinating materials. In many instances, proper filtration is sufficient where the source of the water supply proves to be non-contaminated. Other sources, which show contamination, are chlorinated to the extent that harmful bacteria is removed.

Through education of the water works operators in proper procedures of chlorination and filtration, especially keeping filter beds clean, potable water supplies have been increased. Daily checks are made to determine water purity.

A survey is currently underway to obtain information regarding immediate and long-range requirements for personnel, new additional equipment, replacement equipment, parts and supplies necessary for the efficient operation of each water works plant in Japan. This survey will also determine emergency requirements to place installations in operable condition.

When this data is completed it is then planned to allocate rehabilitation materials, by priority, to those installations whose requirements are the greatest.

Iron pipe is still in short supply, however, cement and other building materials are becoming more available, with considerable quantities having been allocated to various prefectures having emergency requirements. Upon completion of the above survey, it is anticipated that new construction and repair will proceed under a more coordinated nation-wide program.

Water supply systems, which were only constructed in the larger cities, have been repaired and expanded as fast as materials and funds have permitted.

The rehabilitation of water works plants and systems is a long-range program designed to ultimately raise the overall water purification and supply standards throughout the nation.

Progress in rehabilitating sewerage and waste disposal methods have necessarily been slow due to age-old Japanese customs, plus the fact that few cities had any resemblance of modern sewerage or waste disposal systems.

The poor fertility of the soil necessitated huge imports of fertilizer from Korea, China and other areas which, when cut off by the war, forced the Japanese farmer to rely solely on night soil to fertilize his land. Old customs of collection and disposal are still in use.

During the occupation, the sewerage problem has been confined to keeping the existing systems clean and free from refuse to permit uninterrupted flow of waste material and to procure covers for the open drainage systems so numerous throughout the nation. These systems are also periodically sprayed with 5% DDT residual effect spray to eliminate mosquito and fly problems.

The Japanese were also directed to construct covers for all night soil storage tanks as one means of improving the sanitation problem. There are several waste disposal installations scattered throughout Japan which are now active in producing fertilizer, however, their output is small compared to national requirements. The construction of additional waste disposal installations is currently being studied by the Ministry of Welfare.

Refresher Courses

The lack of qualified sanitary personnel was recognized at the beginning of the sanitation program. Only two trained sanitary engineers, who were trained outside of the nation, were found in all Japan as no attempts had ever been made to establish sanitary engineering courses in Japanese colleges or universities. Training schools, designed to instruct the more qualified in modern sanitary practices, were held in the various regions of Japan. These were of one or two week duration and, while a definite aid to modern sanitary education, proved too short to adequately cover all phases of the sanitation program.

Upon the reorganization of the Institute of Public Health in Tokyo, in the early part of 1947, a course for Public Health Sanitarians was included in the teaching program. The first class started in May 1947, with five classes totaling 220 students, having been graduated to date. These are three-month intensive refresher courses given to selected Japanese prefectural and local sanitary personnel. This program has greatly aided in the improvement and efficiency of sanitary teams.

In May 1948, a refresher course for Public Health Engineers was included in the Institutes' training program. This is also of three-months duration and will accommodate between 45-50 students. These classes will be continued.

Seven of the nine regions in Japan now have Military Government Sanitary Engineers attached to the regional MG teams. Working in close harmony with Japanese regional and prefectural sanitation personnel in their respective areas, they have been able to closely supervise and guide all sanitary activities and improve on-the-job training in all phases of the sanitation program.

Future Programs

A research committee has recently been formed to advise the Economic Stabilization Board of the Prime Minister's Office on sanitation problems, and to study and recommend long-range plans for the improvement of sanitary conditions. Composed of three University of Tokyo School of Engineering professors, and a representative from each of the Ministries of Welfare, Labor, and Agriculture and Forestry, the committee's recommendations are expected to provide concrete data and plans for the rehabilitation and expansion of sanitary facilities.

Besides a continuation of current programs, future plans also include the retention of sanitary teams on a ratio of 1 per 13,000 population, which will provide 6,160 permanent teams considered necessary to efficiently carry out planned environmental sanitation control and insect and rodent control activities.

It is also planned to establish refresher training schools in each prefecture, contingent upon the ability of graduates from the Institute of Public Health to qualify as instructors for prefectural courses. In addition, plans have been made to establish post graduate schools of sanitary engineering in the leading engineering schools in Japan, open only to individuals holding engineering degrees.

Port Quarantine

Introduction

Prior to the war, the Japanese quarantine system was operated by prefectural and local governments without national coordination. Quarantine provisions, therefore, varied according to local ground rules and lacked uniformity.

While Japanese prefectural quarantine regulations appear to have served the requirements of the nation, they were far inferior to modern international quarantine control procedures.

During the war, barriers that had existed against quarantinable diseases completely broke down. Personnel had been inducted into the various armed services in such numbers that all stations became understaffed. Facilities were stripped of equipment, which was turned into scrap metal urgently needed for military requirements. As the war progressed, quarantine functions gradually ceased, except for incoming and outgoing military personnel.

The disruption of normal functions immediately prior to the capitulation resulted in all quarantine station activities coming to a standstill, and presented a definite threat of the importation of communicable diseases, especially in view of the planned repatriation program.

Organization of Quarantine Stations

The first step to reorganize the quarantine stations was taken with the publication of port quarantine regulations in August 1945, and while stringent compared to the requirements of a modern nation, the high communicable disease incidence in Japan and other nations in the Asiatic area necessitated that strict measures be adopted.

Eight ports were then selected for quarantine stations, a full complement of personnel were assembled and trained, in addition to procuring medical and laboratory equipment and supplies from confiscated Japanese Army-Navy stocks and surplus U. S. Army stocks. This was a high priority undertaking, but utilizing both U. S. and Japanese personnel, a national coordinated quarantine service was formed and placed under the control of the Ministry of Welfare in time to handle all the medical processing of repatriates which began arriving in September 1945.

Under the supervision of the Public Health and Welfare Section and Military Government port quarantine officers, quarantine controls proved successful in preventing the entrance of communicable diseases into Japan. The largest mass repatriation program in history, approximately 6,000,000 persons to Japan and 1,180,000 from Japan, to date, has been completed without incident, and furthermore, at no time in this program has there existed any threat of the danger of diseases among the Occupational Forces. Some 650,000 persons still remain to be repatriated to Japan, principally from Soviet occupied areas.

The following instances are cited as being indicative of the magnitude of the quarantine problem and the value of strict quarantine procedures enforced by the Supreme Commander for the Allied Powers. The occurrence of 711 proven cases of cholera and 479 carriers aboard 114 vessels resulted in 232,907 persons being detained in quarantine. These vessels arrived in Japan from Bangkok, Haiphon, Canton, Kongmoon, Shanghai, Hulutao and south Korean ports. More than 120,000 of these patients had been embarked in Hulutao alone. Two hundred fifty-five cases of typhus fever were discovered among repatriates among 52 vessels, most of which arrived from China, Manchuria and Korea. Two hundred seven of these patients were from middle China. One hundred seven cases of smallpox were discovered on 54 vessels from middle and northern China, Manchuria, Okinawa and Formosa, with China and Manchuria contributing the majority. Constant vigilance and effective supervision has been necessary to prevent the introduction of major epidemics into Japan.

During 1946, there were several small outbreaks of smallpox and cholera in the southwest areas of Honshu and the western area of Kyushu bordering on the Japan Sea. Subsequent investigations traced this to illicit shipping and smuggling of personnel from Korea and the Asiatic mainland. Rounding up these illegal entrants, medical processing and then deportation, has eliminated this danger.

In December 1946, eight seaports of entry and two airports of entry were officially designated as quarantine stations to control the normal entry and exit to and from Japan. In the fall of 1947, the designation of five additional seaports provided for more efficient quarantine controls.

Seaports, currently in operation, are:

Otaru	Nagoya	Mike
Hokodate	Kobe	Hokata
Yokohama	Hiroshima	Nagasaki
Shimizu	Moji	Sasebo
	Kagoshima	

Airports: Haneda and Iwakuni.

In addition to these ports listed, repatriation centers are maintained at Hokodate, Maizuru and Sasebo.

Repatriation from Soviet areas, discontinued during the 1947-48 winter season, was resumed in April 1948. Repatriation centers, which had been kept on a stand-by basis, were placed in full operation on 24 hours notice and were able to resume all functions without delay. Approximately 20,000 repatriates are now arriving each week.

Medical Processing of Repatriates

Medical processing was started immediately upon the arrival of a repatriation ship in port. Ships were placed in quarantine while a thorough examination was conducted on all repatriates, including a check of immunizations.

In those instances where cases of communicable diseases, such as cholera, typhus, plague, smallpox, etc., were found, they were removed to isolation areas, under medical treatment. The remaining repatriates were kept in quarantine for 14 days, pending possible further occurrence of disease aboard ship. At the end of this period, if no additional cases developed, repatriates debarked for processing and transportation to their destination. However, if further cases were found, an additional 14 day quarantine period was required from the date of the last proven case.

When inspections and examinations disclosed no communicable diseases aboard ships, a minimum period of six days, retroactive to the date of embarkation, was required before repatriates were permitted to leave the ship for processing. This was necessitated by the known fact that repatriation points of origin were in areas where cholera, typhus and smallpox were extremely prevalent.

As most vessels in the repatriation program were able to make the trip from the mainland to the reception centers in two or three days, this brief quarantine period permitted a further check on possible communicable disease among repatriate groups.

The greater majority of repatriates did not receive proper medical processing prior to embarking, therefore, included in the medical processing at the repatriation center was all necessary immunization requirements. Repatriates were also given chest x-ray examinations, and in addition had all their clothing and bedding and their person dusted with 10% DDT dust to remove fleas and body lice.

Laboratory facilities, at each quarantine station, were used extensively in proving cases of communicable disease and in determining suspects. Also included was a complete stool examination of each individual.

During the peak of the repatriation program, the repatriation centers at Hakata and Uraga were equipped to process 15,000 repatriates each per day.

Quarantine Regulations

Peace-time quarantine regulations were prepared and became effective in December 1946. The seaports and airports of entry are operated by Japanese personnel under the supervision of Military Government port quarantine officers.

Due to changing conditions, stringent immunization requirements which were necessary in 1946 when the original quarantine regulations were published, were revised in March 1948 to bring them in line with standard international quarantine control.

The current regulations are considered sufficient to control all surface and aircraft entry and exit to and from Japan. No specific future programs are contemplated, except for the continuation of present operations and improvement of control activities.

Laboratories in JapanIntroduction

A limited number of laboratory facilities, both diagnostic and biological, were found in Japan. National standards existed for only two biologicals, diphtheria and typhus anti-serum, which were assayed by the Institute of Infectious Diseases, in Tokyo, for the Ministry of Welfare.

There was no administrative organization in operation, nor were there regulations controlling either diagnostic or biological laboratories. Organisms used for preparing various vaccines differed from laboratory to laboratory, as did the final products.

Investigations revealed that seed strains used in preparing vaccines were in many cases non-antigenic.

During the war, such standards as were maintained, practically ceased to exist due to conversion of all manufacturing facilities to the war effort and induction of personnel into the various armed forces. Considerable laboratories and laboratory facilities were destroyed.

As a result of the nation's isolation the medical profession was not able to keep up with modern techniques and developments in the laboratory field. Many doctors in Japan were inclined to research and although there were several qualified laboratories and a few capable research men who were doing noteworthy work, research laboratories, in general, were inferior and the programs being conducted were of doubtful quality.

Vaccine Production and Assay

The necessity for producing biologics to control communicable disease was of primary importance at the beginning of the Occupation. One of the first projects was to produce sufficient smallpox vaccine to immunize the entire population in Japan. This was accomplished by the Japanese, using techniques with which they were familiar. Although the techniques and standards were not considered entirely satisfactory, they were able to produce a potent smallpox vaccine in sufficient quantities to complete the nation-wide immunization program.

The Japanese also produced considerable quantities of diphtheria toxoid, typhoid vaccine and cholera vaccine. These were all produced without minimum standards or assay. Minimum standards were provided for typhus vaccine with techniques and assay under supervision of the Public Health and Welfare Section.

A laboratory control program at the national level was inaugurated in the fall of 1946, followed by the creation of a laboratory control section in the Ministry of Welfare. Official minimum requirements for Japanese produced epidemic typhus vaccine, typhoid, paratyphoid and cholera vaccine were then promulgated and distributed to the manufacturing laboratories.

Army strains of the various vaccine organisms were imported from the United States and only those laboratories capable of meeting the minimum requirements were permitted to manufacture vaccines. As the program developed, minimum standards were subsequently established for diphtheria toxoid, smallpox, whooping cough and BCG vaccine. Other standards are being developed and approved as rapidly as possible.

The National Institute of Health, staffed by some of the leading scientists in Japan, was established in May 1947, under the jurisdiction of the Ministry of Welfare. Here, the highly technical assay of biologic and anti-biotics, is carried out in addition to experimental research on disease control, especially communicable disease.

A system of national and local laboratory inspectors was subsequently organized to carry out surveillance of diagnostic and biological laboratories in observance of official directives and regulations. Instruction courses for inspectors and manufacturers of biologics are being given to assist in the establishment of the national laboratory program.

While the task of vaccine production and assay proved to be tremendous, close surveillance to insure a safe and standard product has enabled the Japanese laboratory facilities to produce sufficient vaccines to currently meet, with few exceptions, all requirements.

Research

Research activities on the production and assay of biologicals and anti-biotics, including research on disease control, is being carried out at the National Institute of Health in Tokyo. While this program has only developed during the past nine months, plans provide for an expansion of their research activities. (Note: More information on the activities of the National Institute of Health will be found under this subject.)

--Future Programs--

In order to eliminate the defects in the present system of manufacturing and distribution of BCG vaccine, which has been increasing in importance, a plan has been formed whereby all such vaccines will be produced in one central laboratory, under close supervision. Minimum standards now in process of preparation will include lyophilization to prevent rapid loss of potency inherent in the present vaccine.

Future plans also provide for the establishing of standards for biological and diagnostic laboratories, with surveillance over the laboratories to insure that these standards are met.

The National Institute of Health

--Introduction--

An Institute under central government supervision designed to control the assay of biological products, as well as conduct fundamental research on problems of national importance in the field of public health, did not exist in Japan. The nearest approximation to such an organization was the Institute of Infectious Disease in Tokyo which had been in existence for many years. Formerly under the Home Ministry, it was transferred, in 1933, to the Tokyo Imperial University which was under the control of the Ministry of Education.

The primary function of the Institute of Infectious Diseases was that of a medical institute for the university. As a secondary function, it acted as an agent for the Ministry of Welfare in matters relating to licensing of biological laboratories and assay of their products. At the same time, it became one of the largest manufacturers of biologic products in the nation, thus the Institute sat in judgment over the products of other commercial manufacturers as well as its own products which were produced in competition with private enterprise.

Organization and Functions

Although the need for an official government public health Institute under the direct control of the Ministry of Welfare was very evident, a considerable period of time elapsed before funds, facilities and personnel could be obtained to organize such an institution.

It was not until 21 May 1947 that the National Institute of Health (NIH) was formally dedicated as an official organ of the Ministry of Welfare. It is an independent organization directly responsible to the Minister of Welfare and has been staffed with leading scientists of Japan, gathered from various universities throughout the nation.

The primary functions of the National Institute of Health are:

1. The establishment of standards for biologic products and qualitative control of all biologicals and anti-biotic products in Japan.
2. The conduct of fundamental research projects on problems of national importance in the field of public health.
3. Upon the resuming of international relations, to act as the official Japanese organ in maintaining liaison with similar institutions throughout the world.

The Institute has three departments, namely: Department of Research, Department of Assay and Department of Experimental Production of Biological Products. These departments are further broken down into 14 divisions which adequately handle all necessary functions and responsibilities of the Institute.

Research Programs

During the summer of 1947, American Scientists, working jointly with Japanese Scientists, conducted or continued research studies on the following projects:

1. Research studies on Ekiri. An American Scientific Mission was in Japan for 90 days conducting research studies in Ekiri, a disease of children. Their findings proved that Ekiri was primarily caused by the loss of calcium in the blood. Under their guidance, steps were taken to control this disease. The work has continued under the auspices of the Japanese scientists, with training classes being held to teach the Japanese the techniques of evaluation of the levels of calcium in the blood.
2. Research studies on Japanese B encephalitis, which originated in the early summer of 1946, have continued to date.
3. Research studies on schistosomiasis, which were started in 1946 have been continued to date and include surveillance of various prefectures where this disease is quite prevalent.
4. Genetic studies on the victims of the atomic bomb in Nagasaki and Hiroshima have, in coordination with the American Atomic Bomb Casualty Commission, been conducted since their origination in the fall of 1945. Establishment of branch field units in the Nagasaki and Hiroshima areas, with a central department in Tokyo, are currently being placed into effect.

During this period, anti-biotic research studies have made considerable progress. A penicillin pilot plant was completed in May 1948, and marks the first step in the conversion from the submerged process to the pilot plant process in the penicillin production program.

The assay department at the National Institute of Health has increased its scope of activity to embrace diphtheria toxoid. Assay on other products, for which minimum requirements exist, has continued.

--Future Programs--

Future programs include the organization of a department of clinical bio-chemistry stimulated by the findings of the Ekiri Commission. Previously there had been practically no emphasis upon the necessity of clinical bio-chemical data in the treatment of diseases. The need to disseminate practical knowledge will necessitate the functioning of this department as both a teaching and research unit.

There being no cancer research project established under any central governmental institute, future plans provide for a department of cancer research.

Plans have been formulated to integrate the studies being conducted on the atomic casualty research program under a separate department.

Sizeable increases in the size and scope in the assay department is contemplated. Minimum requirements will be established for those vaccines for which minimum requirements do not now exist.

The Institute of Public Health

--Introduction--

Prior to 1930 Japan did not possess an institute whose primary function was the teaching of public health. During the early 1930's the Rockefeller Foundation became interested in the public health problem in Japan and subsequent negotiations between the Foundation and the Japanese Government resulted in the establishment of the Institute of Public Health.

Construction of the present facility was begun in 1935 and completed in 1939. It is a modern seven story building, well-equipped, and constructed entirely by funds donated by the Rockefeller Foundation.

The Institute of Public Health, however, did very little teaching of public health and confined their activities largely to the research field. In 1943 the Ministry of Welfare occupied the building and remained there throughout the war.

Reorganization

There was a great need in Japan for doctors educated in public health. The only qualified public health officials were the few who had been educated abroad, principally in the United States, England and Germany; so, early in 1946 a program was adopted to reestablish the Institute as an institution for teaching public health.

Initiation of this program was delayed due to lack of funds, facilities and personnel, however, early in 1947 members of Public Health and Welfare Section, Ministry of Welfare officials and key members of the staff of the Institute of Public Health completed plans for initiating

refresher courses for seven types of public health personnel and, at the same time, made arrangements to have the Ministry of Welfare vacate the building.

Public Health Refresher Courses

The first class for public health nurses began on 2 April 1947 and the initial class for public health officers (doctors) and public health sanitarians began on 16 June 1947. On 9 January 1948 classes were opened for pharmacists and veterinarians.

In May 1948 courses for public health nutritionists and public health engineers were opened which completed the original plan of seven types of training courses for public health personnel.

The following numbers of classes have completed courses to date:

	<u>Number of Classes</u>
Public Health Officers (doctors)	5
Public Health Nurses	4
Public Health Sanitarians	5
Public Health Veterinarians	3
Public Health Pharmacists	3
Public Health Nutritionists	1
Public Health Engineers	1

These classes are short, intensive training courses of two, three or four months duration, for personnel currently on duty with public health agencies throughout Japan. Approximately 40 to 50 Japanese personnel can be accommodated in each class.

In June 1948, a public health consultant from the Rockefeller Foundation was placed on loan, for one to two years, to the Public Health and Welfare Section SCAP to coordinate all the activities of the Institute of Public Health. Under his direction all training courses will be improved and expanded.

--Future Programs--

Future plans provide, primarily, for expansion and improvement in the educational facilities at the Institute. The need for larger class accommodations has been recognized which will permit a greater number of students to be trained. Improvement in the quality of instruction will receive high priority.

Public Health Education

--Introduction--

A public health education program has never existed in Japan and the idea was entirely foreign to Japanese concepts of public health administration.

During the first two occupational years, little effort was directed towards such a program due to the urgent need to establish measures for the prevention and control of communicable disease.

In the fall of 1947, recognizing that education of the population in public health was essential to the many various public health projects, plans were made to develop a nation-wide educational program.

The Health Education Liaison Committee

The first step to coordinate health education activities was taken

with the establishment of the Health Education Liaison Committee composed of representatives of the various Ministries of the Japanese Government.

The primary function of this committee is to establish definite policies and coordinate activities pertaining to the execution of health education programs for general public health education and health education in these schools.

With SCAP approval the Ministry of Welfare then inaugurated a long-range plan for health education in Japan. This plan, which embraces the national, prefectural and local levels, stresses the necessity for close correlation and coordination of all health education activities.

Dissemination of Public Health Information

An Information Section, established in the Ministry of Welfare, serves to coordinate all information-education activities of the Ministry. It functions as a sub-section of the General Affairs Section but is directly responsible to the Vice-Minister.

A committee of Japanese personnel was made responsible for assembling and checking health subject material for release over a daily radio program which is devoted exclusively to the promotion and advancement of public health. The Ministry of Welfare and the Broadcasting Company of Japan have closely cooperated in the execution of this phase of the health education program.

The Ministry of Labor, in cooperation with the Ministry of Welfare, inaugurated a health information-education program in an effort to raise the standards of health and sanitation in the coal mining areas in Japan.

Dissemination of public health information is also made through other media, such as magazines, newspapers, and posters. The public is being kept continuously aware of health education. That this program is gaining success is evidenced by the numerous letters that are forwarded from listeners.

The Public Health Train

On 1 November 1947, in Tokyo, an impressive ceremony was held for the opening of the Public Health Train Exhibit. This train, consisting of three converted railway coaches, contains exhibits, charts, diagrams, pictures and models dealing with nutrition, tuberculosis, venereal diseases, and other communicable diseases, parasitic diseases, public health nursing, dental hygiene, social security, environmental sanitation and veterinarian activities.

This train has completed exhibition tours of three regional areas in Japan in which approximately 500,000 people have been given the opportunity to view the exhibits on display. The train will be kept in constant operation until the entire nation has had an opportunity to see it.

Future Educational Plans

Future plans consist of a continuance of the tours of the public health train exhibit with specific efforts to have the exhibit shown in the more remote areas of the nation where public health and sanitation lags far behind modern standards.

It is also planned to continue and improve the current information-educational programs with efforts directed to the health education programs in the schools.

Chapter 3

MEDICAL CARE

Medical EducationIntroduction

Japan possessed an adequate number of doctors, however, many were graduates of second class medical schools and consequently their knowledge of medicine and ability to practice was limited.

All schools had operated under the didactic German system for years, with little emphasis on laboratory or clinical teaching. Progressive advancement was further hampered because qualified instructors refused to participate in medical school teaching preferring to confine their activities to selected groups training for the higher degree of Doctor of Science in Medicine.

Prior to 1932 the educational requirements leading to a degree of Doctor of Medicine consisted of six years of primary school, five years of middle school, three years in the science section of a university preparatory school (Koto Gakko), followed by four years of medical school at university level. A certificate of graduation from a medical school permitted the legal practice of medicine and automatic issuance of a medical license. No examination was required.

Concurrently, there existed a number of medical technical colleges (Semmon Gakko) which accepted graduates of the middle schools and prepared them for the practice of medicine after a four year course of study. Graduates of these schools were also automatically issued a medical license.

Although the medical degree obtained from the technical college was different from that granted by the university medical school, the licensee was in no way limited to the extent of his practice.

The Japanese Medical Association was a governmental body of doctors in which membership was compulsory, with the society dedicated to the control of medical practice and the upholding of national policy.

A group of approximately 60 doctors trained in American, English or German medical schools formed a nucleus of the more advanced professional men and, until the nation's isolation during World War II, were able to keep abreast of modern developments in the medical fields.

During the war with China and later World War II medical education became geared to wartime requirements. The system of medical technical colleges (Semmon Gakko) was rapidly increased to produce doctors for the colonies and the Army and Navy Medical Corps. Whereas, prior to 1942 only 36.7% of medical graduates were from the 18 established technical colleges (second class schools), the urgent need for medical personnel resulted in these schools expanding to 51 in 1945 and producing 61.2% of the nation's medical graduates. If this system had continued, it was estimated that by 1949, 76.4% of the approximate 8,870 annual graduates would have received certificates from these inferior schools. There were 47,798 doctors in Japan including instructors and research personnel (August 1945).

The looseness of medical education standards and the development of medical schools with abbreviated courses allowed a great number of entirely unqualified persons to practice medicine in Japan.

The Council on Medical Education

Japan lacked an agency through which reorganization of the medical education system could be initiated. The Japanese Medical Association evidenced no interest in such proposals therefore, it was necessary to group together Japanese doctors known to possess progressive ideas and representing the leading medical colleges of the nation.

A series of group conferences subsequently led to the formal organization of the Japanese Council on Medical Education in March 1946. The Council has since met in regular monthly sessions and their proposed reforms and subsequent recommendations under Public Health and Welfare Section guidance in reorganizing the medical education system had aided immeasurably in the development of the program.

The Council on Medical Education has recently been absorbed into the newly reorganized Japan Medical Association and now functions in an advisory capacity to the association by making recommendations to the Ministry of Education regarding future changes in medical educational requirements. The Council also has representation on The Japan Educational Reform Council Accreditation Committee and will function as the medical representative within this body in the future accreditation of medical schools.

Educational Reforms

In adopting proposed educational reforms it was realized that students, currently enrolled in the medical technical colleges, would have their education abruptly halted if immediately forced to meet the new educational program (identified as the 6-3-3-2-4 system) which required two years of college level pre-medical education and four years of medical school at university level following completion of primary school (6 years), lower secondary school (3 years), and upper secondary school (3 years), a total of 18 years. Therefore, it was agreed that the complete adoption of this program would not become effective until 1950.

The new medical curriculum, as adopted, places emphasis on practical methods of instruction, including demonstration, experiments in laboratories, anatomical dissection and attendance at autopsies. Particular care will be devoted to the practical instruction of students at the bedside and in dispensaries. Forty-seven per cent of the required hours will be devoted to the teaching of preclinical subjects, with a preponderance of these hours devoted to practical laboratory work. The distribution of time allotted to the various preclinical courses will compare favorably with that recommended by the Council on Medical Education of the American Medical Association. Fifty-three per cent of the total medical school curriculum will be devoted to clinical teaching and lectures will be utilized only as supplementary to the clinical instruction. Because of the increase in the number of medical schools over that existing prior to 1938, and the limited teaching facilities, 40 to 80 students per class will be accommodated, depending upon the capacity of the school.

An interim program was then established which required one year pre-medical schooling for the 1947-48 school term and then entrance into the four year medical course on a university level, and two years pre-med for 1948-49 prior to medical school. Although in 1950, two years of pre-medical cultural education will be required, three years of pre-medical preparation are recommended before entrance to a medical college. In addition, the medical school graduate must spend one year of rotating internship in an approved hospital in order to qualify for the National Licensure Examination.

While the qualifications of many hospitals are sub-standard, hospital reforms are slowly progressing with the greatest care being exercised in

selecting institutions that can provide good practical medical instruction for interns. Hospital reform is, therefore, vital to the effective clinical teaching of medicine.

Educational reforms also provide for the elimination of all medical technical colleges (Semmon Gakko) by 1952. A survey was made to determine the semmon gakko that could be conferred to class A colleges (class A), and the schools that were of such inferior standards as to require immediate dissolution (class B).

Students currently enrolled in class A semmon gakko will be permitted to graduate, but will require one additional year of schooling at university level plus one year internship to qualify for the national licensure examination. Students that were enrolled in class B schools were integrated into class A schools, one year behind their current class, and will qualify for the national examinations as prescribed for class A semmon gakko.

A new policy provides an additional means of developing Japanese medical education by permitting Japanese travel abroad for specialized cultural and educational purposes, subject to a sponsor who guarantees all expenses and financial support.

The Rockefeller Foundation is currently sponsoring two Japanese doctors for one year graduate level work in public health, one at Harvard University School of Public Health, and the other at John Hopkins University.

Other institutions and agencies have expressed a desire to sponsor qualified doctors and it is anticipated that increasing numbers of Japanese will benefit from these opportunities.

The Japan Medical Association

Reorganizing the Japan Medical Association along democratic lines, with removal of all governmental influence, subsequently resulted in the adoption of a new constitution on 31 August 1947. Patterned somewhat after the American Medical Association, temporary officers were elected until 9 March 1948 when the first national election was held.

The new society is dedicated to promote medical ethics, to improve and propagate medical knowledge and techniques, and to advance public health as a means of improving the social welfare.

Membership, voluntary for those individuals who meet the professional and ethical standards required, is now being sought by the general practitioners as well as by medical scientists. Previously, medical educators and researchers were rarely affiliated with the association which is now regarded as a representative body of all physicians in Japan, regardless of their spheres of activity.

Prefectural and local associations have been formed under constitutions patterned after the national organization.

The reorganization now complete, efforts are being directed towards counselling and guiding the new association to permit their recognition among similar associations of other nations.

Medical Licensure

National examinations inaugurated by SCAP, to obtain a license for the practice of medicine, were held for the first time in Japan in April 1947.

The Medical Association had established a governing body of physicians known as "The Council on Examinations for Medical Licensure" which, in turn, selected a committee of 17 examiners who were leaders in various medical fields.

The examining committee prepared and conducted the original and subsequent national examinations, which have been held at six month intervals to date, (October 1947, April 1948). Students who fail to qualify for licensure are permitted to retake the next scheduled examination.

The Council on Examinations for Medical Licensure establishes the policy for each national examination and supervises the work of the examining committee.

In the last examination conducted in April 1948, out of 951 applicants, 424 or 44.5% failed to qualify for licensure, principally due to failures in pre-clinical subjects. The examinations cover a four day period and require approximately 20 hours of written tests. Although somewhat rigid, with a high percentage of failures, the examinations permit only qualified persons to obtain a license to practice medicine.

The latest report shows a total of 67,981 doctors in Japan, including those engaged in teaching and research.

The Medical Examiner System

Early in the occupation exaggerated Japanese press and radio reports on causes of death, attributed to starvation, among cadavers found on Tokyo streets resulted in the Tokyo Metropolitan Health Bureau being instructed to conduct autopsies on each body at the Tokyo University Medical School.

The system was placed in effect on 24 November 1945 and quickly determined the truth of the situation in that the deaths were all caused by disease.

In April 1946 a revised system was instituted covering all deaths having public health importance. This proved of such value that it was extended to include all the large metropolitan areas in Japan. By September, the examiner system was operating in Tokyo, Osaka, Yokohama, Kyoto, Nagoya and Kobe.

There being no legal authority for the conducting of autopsies, the Japanese Government was directed in December 1946 to establish medical examiners offices in the principal cities of the nation. A subsequent law provided for the appointment of a chief medical examiner, who is a physician and a pathologist, to conduct all post mortem examinations on persons dying by criminal violence or neglect; accidental injury; suicide; or suddenly when in apparent good health; or when unattended by a physician; or in prison; or in any suspicious or unusual manner.

The use of cadavers for teaching anatomy was illegal. Under this new law, bodies that remain unclaimed in the possession of the medical examiner for 48 hours may, for the purpose of advancing medical knowledge, be surrendered on request to the head of a recognized medical school. It requires the chief medical examiner to keep full and complete records, properly indexed, and to submit a monthly report of his findings to Military Government authorities.

New Legislation

The problem of regulating some 250 separate questionable quasi-medical practices in Japan has been partially solved by the passage of a law which eliminates all but the practice of moxa-cautery, acupuncture, massage and

judo-bonesetting. Included in the Ministry of Welfare ordinance, based upon this law, are educational prerequisites and standards for authorized schools.

The National Medical Treatment Act of 1942, which included physicians, dentists, nurses and pharmacists, has been replaced by four separate laws passed in July 1948, one covering medical practitioners. This provides for educational requirements, licensure, etc., as outlined in the preceding paragraphs under Medical Education.

Medical Literature

The international exchange of medical text books, journals and research data had ceased in 1939 resulting in a stagnation of normal educational development. Consequently, early in the occupation, there arose a great need for modern medical literature. As Japanese yen was not permitted as a medium of exchange outside Japan, subscriptions to foreign medical journals and publications were impossible.

The situation was partially alleviated by loans and donations from the Surgeon General's Office, Washington, D.C. Medical text books and other medical publications were also furnished each Military Government Team and are available for loan to Japanese prefectural doctors.

The demand however, far exceeded the amount of literature available. Finally, after two years of effort and in conjunction with the Civil Information and Education Section of SCAP, arrangements were completed in which republication rights of certain American medical text books and journals would be authorized Japanese publishing firms. Implementation of the program has been proceeding satisfactorily and within the next 60-90 days some 350-400 selected text books are expected to become available for republication.

In June 1948 postal regulations were revised to permit American and other nationals to mail books or journal subscriptions direct to Japanese nationals through the international mails. Considerable interest has been stimulated by this announcement.

The Army Medical Library, Washington, D.C., is also interested in the medical literature program and is currently preparing a shipment of library duplicates, some fairly modern, which will be donated to medical school libraries and such institutions as the National Institute of Health and the Institute of Public Health. The library also sent a representative who arrived in July 1948 to plan for the restoration of the international exchange of medical literature.

Fulfillment of these projects will greatly aid the medical literature problem and should provide the Japanese medical profession with much valuable data, heretofore lacking.

Future Programs

Future programs provide for continuous supervision to bring the current medical literature plans to a successful conclusion and determine that proper distribution is made to all material as it becomes available.

It is also planned to establish a post-graduate medical education program and to elevate the educational and professional standards of the services closely allied with medicine, such as x-ray technicians, laboratory technicians, physiotherapists, etc.

Endowments by private individuals and organizations for the establishment of medical scholarships and medical foundations will also be encouraged.

Another future program is a proposed redistribution of doctors in Japan so that rural districts are provided with medical service.

The efficient use of present medical equipment will also be encouraged and, at the same time, discourage the duplication of services by individuals as well as closely allied institutions.

Continuous surveillance will be exercised over all reforms and projects to observe that, as they near completion, they will be adaptable to the future Japanese economy.

Hospitals, Leprosaria and Sanatoria

Introduction

Concentration of the nation's efforts in meeting military requirements during World War II similarly had its effect in the physical deterioration of hospitals and other medical institutions. One thousand twenty-five hospitals, with a total bed capacity of 53,000, had been destroyed. Large quantities of heating and central cooking equipment had been removed for scrap metal. Military medical installations held large quantities of drugs and medical supplies which were urgently needed for treatment of the civil population, consequently many hospitals had been without x-ray film for at least three years, were unable to procure adequate amounts of medicine, and also found it necessary to wash and reuse dressings.

All Japanese hospitals were "closed" institutions with a paid staff of doctors. Most Japanese civilians received medical care by going to hospitals rather than the doctor's office as is common in the United States. Therefore, all hospitals had large out-patient services from which in-patients were obtained for the hospitals. The private practitioner who had no connection with the hospital staff found it necessary to provide some measures in which he could retain the care of his patients. As the result, thousands of inferior grade hospitals of ten beds or less were established by private practitioners to hospitalize their own patients, thus retaining the care of their patients as well as benefiting from the medical fees derived from such care.

Surveys determined that physical facilities for hospitals and other medical institutions of more than ten beds, although suffering heavy damage, existed in sufficient numbers to provide adequate hospital beds for the needs of the civilian population; however, the lack of equipment, supplies and competent personnel resulted in these institutions operating in a very sub-standard manner. The poor medical service being rendered, plus the fact that hospitals could not provide ample food for their patients, resulted in a small percentage of the available beds being occupied.

National Hospitals Established

There were 497 army and navy hospitals, with approximately 100,000 patients, in existence at the time of surrender. These institutions were turned over to the Home Ministry, then later transferred to the control of the Ministry of Welfare and re-established as national hospitals. The national hospitals located at ports of entry were also utilized to process repatriates.

Preferential treatment to military patients was discontinued and all national hospitals were required to render services that would meet the needs of the civilian community. Although a large number of military patients still require hospitalization, approximately 50% of the total patients currently hospitalized are civilians.

Many national hospitals have been converted to general hospitals, tuberculosis sanatoria and leprosaria. The Ministry of Welfare is currently

operating 97 national hospitals with a bed capacity of 30,000, in addition to 142 tuberculosis sanatoria with a capacity of 43,332; ten leprosaria with 18,890 beds; two mental hospitals with 1,000 beds; two hospitals for head and spinal injuries with 340 beds, and seven hot springs with 742 beds.

All the national hospitals are now "open" hospitals wherein qualified practicing physicians are permitted to continue treatment of their hospitalized patients.

Bed Status Reporting

Early in the occupation a weekly reporting system on hospitals, by prefecture, was established which included the number of beds available, beds occupied and number of out-patients treated.

There are at present 3,423 hospitals including national hospitals, of more than ten bed capacity in operation in Japan, with a total bed capacity of 207,906. This provides one bed for approximately each 375 persons. Latest reports indicate that 100,204 of these beds are occupied. During 1947 the number of occupied beds ranged from 95,000 to 115,000. An average of 303,000 persons received out-patient treatments weekly during 1947 (See Chart No. 16).

Beginning 1 June 1948 the weekly reporting of hospital bed statistics and out-patients treated was changed to a monthly report.

Hospital Administration

Changes in the operation of Japanese hospitals, to bring the standards of treatment up to modern levels, are underway. Such changes are so interwoven with the medical education program, the nursing education program, the availability of qualified physicians, medical investigators, plus hospital administrators, that improvement in hospital administration will not take place rapidly. Considerable progress has been made in providing better nursing care for patients, establishing central kitchens, securing increased rations, as well as improving general sanitary conditions. The age old Japanese custom of permitting relatives to live in the same room with the hospital patient, thereby preparing meals and providing care, is being eliminated by establishing central kitchens and regular visiting hours.

Career officers of the Japanese Army and Navy who formerly made up the majority of the professional employees of the hospitals have, as of 1 May 1948, been completely eliminated. The staffs of these institutions are now 100% civilian practitioners with no former military affiliations. A favorable ratio, of one physician to every 24 patients, now exists.

An early recognized reform was the need to eliminate the small hospitals, of ten beds or less, where it was known that inferior medical practices existed. The Japan Medical Association established a Committee on Standards for Hospitals and their proposed recommendations made it impossible for these small hospitals to continue to exist as hospitals.

In July 1948 the Diet passed the Medical Service Law which provides a legal basis for hospital standards. Under this law, these small independent hospitals may continue to exist as clinics where minor surgical or simple diseases may be treated, but no patients may be confined more than 48 hours unless an emergency exists in which case the approval of the local health officer must be obtained.

The law further stipulates that a minimum of 20 beds must be available to obtain hospital classification, provides for the regulating of medical

fees in the hospitals, sets forth the hospital standards that must be met and also recognizes government grant-in-aid to public institution facilities for purposes of construction, repair or addition, but not for operational activities.

This new law is a major step forward in hospital reforms and its full implementation will be given close surveillance to assure that established standards are met and maintained.

The lack of competent hospital administrators in Japan is another contributing factor to more rapid progress in raising standards. The Ministry of Welfare recently established a committee under SCAP guidance, to study this problem and provide for faculty, curriculum and teaching facilities. The committee recommended that one of the national hospitals be developed as a model hospital and that facilities be provided, within this hospital, for the practical training of administrators. The first class is scheduled to start 1 September 1948 with thirty directors of national hospitals being enrolled in the initial course of three weeks' duration. Upon completion of this course, subsequent courses will follow pending establishment of a permanent three months' course, which will train directors of all hospitals, public and private.

The First National Hospital in Tokyo has been selected for development into a modern institution. Plans have been completed for this conversion, conforming to standards for hospitals as established by the Medical Service Law. The development of this hospital has been determined as the first project leading to the establishment of a national medical center. The hospital will serve as a model for the development of modern hospitals throughout Japan, and is the first step in a plan creating at least one model hospital in each prefecture which in turn, will be used for similar courses in order to raise the standards in all hospitals within the prefectures.

Future Programs

The completion of the model hospital and the opening of the hospital administrators training course is a vital part of future plans and will be closely supervised.

Under study is a plan for the education and rehabilitation of patients in tuberculosis sanatoria, many of whom are of school age.

Future programs also provide for continued supervision and guidance of the projects currently in progress.

Dental Affairs

Introduction

At the beginning of the occupation all dental activity had completely collapsed. Out of 140 dental equipment and material manufacturers only 11 remained in existence after the war. Fortunately, these 11 firms were the largest producers and subsequently managed to maintain production at about 50% of the pre-war rate.

Eight dental schools remained after the war, one being operated by the National Government, one by a prefectural government and the remaining six by private corporations. Only three of these schools had escaped damage by air raids.

Most all clinical and laboratory equipment had deteriorated or was appropriated for scrap metal; gas, water and electricity had been stopped

or reduced as a result of destruction to these facilities. Nearly 6,000 private dental clinics were destroyed by air raids. All dental hygiene in public schools had ceased due to the shortage of dentists and dental materials.

Many faculty members and students had joined the military services and the remainder worked part-time in factories or on farms. Courses were shortened and revised to produce more dentists for the armed forces. The German language was used in teaching and was also utilized in the instruction system.

An examination for licensure was not required of practitioners, consequently professional standards were low. This also applied to dental hygienists. The Japan Dental Association was a quasi-governmental organization with compulsory membership amounting to some 20,000 members.

The Council on Dental Education

The Council on Dental Education was established early in the occupation to recommend educational reforms. One of the first steps taken was the release, on a quarterly basis, of precious metals for dental purposes which was approved by the Reparations Commission.

Three years were added to preliminary schooling as a requirement for entry into dental college. The entire dental school curriculum was revised, assigning appropriate hours to subjects according to their importance, eliminating those considered irrelevant and adding new necessary subjects. Laws were passed which established university level standards for all dental schools.

These educational reforms became known as the 6-3-3-2-4 plan (1946) of dental education and consisted of six years of primary school, three years of lower secondary school, three years of upper secondary school, two years of pre-dental schooling at university level followed by four years at an approved dental college.

The Council on Dental Education also was instrumental in establishing the National Board of Dental Examiners whose responsibility is to prepare and conduct the national examinations for dental licensure. These examinations, conducted every six months, began in April 1947. Approximately 3,000 students have qualified for the three examinations to date with 70% having been granted a license to practice dentistry. Those who fail are permitted to retake the next scheduled examination.

The Japan Dental Association

Organizing a new Japan Dental Association, divorced from government control and influence, was finally accomplished by law on 1 November 1947 which dissolved the old association at the same time.

Adoption of a new constitution and the first national election of officers, under democratic methods, was held on 25 March 1948. Throughout Japan all prefectural and local groups have now formed similar new societies, based on the national constitution.

The present association, although new, is making steady progress and will be given all necessary counsel and guidance to permit its recognition among dental associations of other nations.

Educational Progress

Educational reforms have been making steady progress. In 1946 two dental schools were granted university standing permitting them to accept

pre-dental students under the 6-3-3-2-4 plan. Three more schools attained this status in 1947 leaving three out of the original eight who have not, as yet, met the new standards. In order to determine that dental schools are meeting the standards set by the Council on Dental Education, the Ministry of Education appointed a board of school inspectors who periodically check on the schools granted university standing.

The first group of students to enroll under the present two year pre-dental and four year dental course at university level will graduate in 1952. They should be more advanced and more capable dentists. In the meantime students, who were pursuing courses when the new plan was placed into effect, will be permitted to graduate without additional schooling but are required to successfully pass the national examination.

An important part in the educational program has been the regular monthly meetings of the faculties of all schools in which each basic and dental subject in the curriculum is discussed in order to improve teaching methods.

Another significant step was the dissolution of the war-time Dental Materials Control Company and the restoration of free trade on dental items with the exception of precious metals.

Rehabilitation of the bombed out dentists has progressed until currently 85% of the original 6,000 have been reestablished in practice. A total of 23,931 dentists are now engaged in the practice of dentistry in Japan.

In connection with the nation-wide health center program a short intensive course to train public health nurses to function as oral hygienists in the health centers was completed in April 1948. Additional courses are being planned.

An active dental health educational program among the civil population is now in progress. Motion pictures and short radio talks on oral hygiene have been presented throughout the nation. Dental hygiene has been re-established in the schools, on a more practical basis, with many volunteer dentists traveling to rural areas for the purpose of conducting examinations and lectures. A recent oral hygiene essay contest conducted in Tokyo and Osaka resulted in 230,000 entries being received, demonstrating the interest that is being stimulated by this program.

The Public Health Train, which started a 2 year nation-wide tour of Japan in November 1947, carries a complete dental exhibit including moving pictures on oral hygiene subjects produced by the American Dental Association. Complete mobile dental clinics, modeled after U.S. Army mobile dental clinics, are being placed in operation for use in outlying school districts. Two such clinics are currently in operation.

A national dental caries program, conducted from 1-10 June 1948, provided free clinical examination to all individuals who applied for such service and in Tokyo, the erection of street booths as an aid in conducting examinations on passers-by, created unusual public interest during this ten day period.

Further advancement in elevating dental school standards was made on 1 July 1948 with the formation of the Japan Association of Dental Schools. Organized to foster and coordinate ideas of mutual interest this association will be an important factor in overall educational reforms.

In the literature field the first increment of dental text books has been revised and rewritten and is currently being printed. Donations and subscriptions from dental associations in the United States, now arriving in increasing quantities due to revised international mail regulations, will augment the limited dental literature supply.

Based on recommendations made by the Council on Dental Education the Dentists Law and the Dental Hygienists Law, passed by the Diet on 4 July 1948, provide a legal basis for the programs now in effect. In addition, the Medical Service Law, passed by the Diet on the same date, carried certain provisions relative to the operation of private dental clinics and dental clinics operated in conjunction with hospitals.

Future Programs

All dental programs have been well established by law. Necessary supervision and guidance will continue to be exercised to determine that satisfactory results are being attained. Of particular importance, however, is the expansion of dental services to all the planned 780 nationwide health centers. This is a long range project which can be completed only as fast as personnel, materials and funds become available.

Chapter 4

NURSING ACTIVITIES

Introduction

While other professional groups and associations concerned with public health and welfare problems of the nation suffered from lack of adequate standards, plus the resultant destruction and deterioration caused by war, the fate of Japanese nursing programs was even less fortunate. Prior to World War II there had been a slight trend toward standardization but even this failed during the war years.

Japanese nurses had never received their due professional recognition. Three separate nursing associations existed under government control and influence, namely the Japanese Midwives Association, the Japanese Nurses Association and the Japanese Public Health Nurses Association, all of which functioned independently of each other. Officers of all the associations were men, nurses and midwives having no voice in management.

During the war nursing education was accelerated to provide personnel for the armed forces. Students were admitted to schools of nursing at an age younger than 18 years and courses were shortened to one or two years. Standards of education, registration and organization had many variations.

Approximately 34,000 nurses were absorbed by the armed forces and, as they were of the more qualified group, this resulted in a depletion of trained personnel for the civilian population.

Based on Japanese reports, there were a total of 39,727 clinical, public health and midwifery student nurses in training at the time of surrender. Graduates numbered 166,341 with 605 training schools being listed.

The majority of the graduates were primarily engaged in midwifery nursing. Few hospitals were utilizing nursing services and the institutions that had nurses on their payroll were using them principally for cleaning and scrubbing activities. Most of the public health and clinical nurses were working for various insurance associations, prefectural and local health bureaus and for private corporations. Nursing services, as exist in modern nations, were hardly known to the Japanese profession except in a few minor instances. The St. Lukes Hospital in Tokyo, built with funds donated by the Episcopalian Mission of the United States and partially staffed by American personnel, maintained a nursing program comparable to an average modern class A hospital and produced qualified graduates. Throughout the nation, however, nursing activities had fallen to a very low standard at the time of surrender.

The Nursing Education Council

An over-all survey of existing schools of nursing and available nursing personnel was organized under the supervision of SCAP. This organization included representatives from the Ministries of Welfare and Education, the Clinical Nurses Association, the Public Health Nurses Association, the Midwives Association, and leaders from various schools of nursing in Japan in which both the large and small institutions were included. This organization became known as the Nursing Education Council and was given the responsibility of improving nursing education standards.

Subsequently, committees and subcommittees were formed to study various phases of the nursing programs and to make recommendations for elevating standards and educational requirements.

Under SCAP guidance the Council has been very active in organizing a modern nation-wide nursing program. Based on their recommendations with supervision and assistance from American nursing personnel, refresher and full time training courses were started, educational standards were raised and registration and licensure requirements were placed into law. The Council has been an important factor in the results accomplished to date.

Demonstration Schools of Nursing

The Nursing Education Council proposed that a model demonstration school of nursing be established to raise nursing standards and train leaders for modern nursing requirements. On 1 June 1946 a school was opened in the Central Red Cross Hospital in Tokyo and became known as the Tokyo Model Demonstration School of Nursing.

Students from the St. Lukes College of Nursing and the Central Red Cross Hospital were merged into one student body, totalling 420 trainees. The faculties of both schools were utilized in addition to a staff of four American nurses who supervise and assist in the teaching programs.

Modern three year courses in clinical nursing are being given with the initial full term class scheduled for graduation in June 1949. Requirements for students that were currently enrolled were changed to conform to new educational standards consisting of revised curriculum, improved text books and literature and more practical training in out-patient, surgical and other departments.

In the fall of 1946 the demonstration school was granted recognition as a College of Nursing by the Ministry of Education, retroactive to June 1946. This was an important step in that the Japanese Government became cognizant of the value of this program.

Two classes have now graduated (March 1947, March 1948) and two new classes have entered school for the regular three year course. Current enrollment is 280 students.

The school has made commendable progress. The staff compiled, translated and published their own nursing procedure manual. Enthusiasm displayed by the students for the opportunity of acquiring a modern nursing education and their cooperation in all the activities associated with the school has played a large part in the over-all results attained.

On 1 May 1948 a second Model Demonstration School of Nursing was opened at the Okayama National Hospital in Okayama City. This school also offers a three year course in clinical nursing. The staff consists only of graduates as no school of nursing had existed for several years. Due to limited classroom and teaching facilities, only 40 students could be accommodated for the initial class made up of ten selected applicants from each of the four neighboring prefectures.

Concurrently in the same hospital, American nursing personnel supervised a two months refresher course for the 45 graduate staff nurses to aid them in supervising and teaching the new students.

Plans are being carried out to expand classroom facilities and obtain additional instructors, thereby permitting a larger quota of students for the next class starting April 1949.

Refresher Courses

Many types of refresher courses have been given since the nursing program started. All have contributed to improved nursing services and advancements in nursing education. American nursing personnel have assisted in

teaching these courses but as more and more Japanese nurses become qualified as instructors American nurses have confined their activities to supervision and guidance.

Several short refresher courses have been held for graduate nurses. These consist of 120 hours of classroom work and practical demonstrations.

A four month refresher course for public health nurses was opened at the Institute of Public Health in Tokyo on 2 April 1947. These courses have continued to date as the original plans provide for 730 nurses to be trained in groups of 50 per class. Nurses receiving certificates from this course will be used to staff health centers and prefectural and local departments of health. Intensive didactic work and practical field experience is included in the curriculum, the field experience being obtained in six health centers in Tokyo and nearby prefectures.

To prepare the nursing personnel of the selected health centers for their responsibility of supervising this part of the program, American nursing personnel conducted a 30 day refresher course in February. Twenty-five nurses were given 96 hours of classroom work and demonstration techniques during this period.

The Japanese National Tuberculosis Association sponsored a six months refresher course in tuberculosis nursing which was completed in June 1947. Certificates were awarded to 24 nurses. This course, shortened to four months, was again repeated in November 1947 with an enrollment of 28 nurses. The third such course is currently being held.

The nurses selected for these courses are given didactic work and practical experience working with tuberculosis patients in sanatoriums, clinics, and at homes. The schedules and subjects taught have been carefully planned in order to be assured that up-to-date material is being given to the students.

In addition to the refresher courses enumerated in the preceding paragraphs, a clinical nursing refresher course of six weeks duration was held at the Nippon Medical University, Tokyo, during September and October of 1947. This course attended by 60 nurses was given to help the clinical nurse personnel meet the new standards as required by recent nursing legislation.

In October 1947 the Midwifery Section of Tokyo-to sponsored a short course of 30 hours for midwives at the Keio University Hospital. Outstanding Japanese obstetricians and pediatricians conducted the lectures which were attended by 84 midwives.

The National Nurses Association sponsored a three week refresher course for public health nurses, clinical nurses and midwives, in Fukushima Prefecture during November 1947. Six surrounding prefectures coordinated in sending 150 nurses to this demonstration.

The Educational Committee of the Tokyo branch of the National Nurses Association sponsored a twenty day refresher course in January-February 1948 for the general staff nurses on duty in Tokyo hospitals.

These refresher courses, given to all categories of nursing personnel, have proven invaluable in teaching the nurses modern techniques and educational requirements for the present day nurse. A total of 3,524 nurses have received certificates for completion of the various courses that have been held to date.

The National Nurses Association

It was recognized early in the occupation that the three nurses associations in existence which were used to control nurses would have to

be dissolved and a new organization formed based on democratic principles. In November 1946 the three associations jointly held their annual meeting in Tokyo. During this meeting a group of 20 nursing and midwife leaders who had been formed as a study group to discuss the organization, function, constitution and program of a new nursing association, presented a proposal to form a national association under the name of the Japanese Midwives, Clinical Nurses and Public Health Nurses Association. It was recommended that membership be limited to actively licensed nurses and midwives and only association members be authorized to hold office.

The assembly of approximately 1,300 nurses favorably voted to establish the new association, adopted a proposed constitution and temporarily elected officers who served until the first annual meeting in April 1947. The four months interim period gave the new association time to complete organization plans, arrange programs, incorporate the association as a juridical person and also provide opportunity for the officers to learn the principles and practices, as well as the duties and responsibilities of holding office. During the April 1947 meeting, in which all prefectures were represented, permanent officers were elected for the ensuing two year period and various committees formed to carry out the many activities connected with the nation-wide nursing program.

On 4 June 1947 the Association was registered as a juridical person and, therefore, became recognized by the Japanese Government. Freed from all government influence and control, the new Association has made steady progress during the past 15 months. Current active membership totals 49,844.

The Nursing Law

Regulations pertaining to nursing activities came under the National Medical Treatment Act of 1942 which also included doctors, dentists and pharmacists. This law was inadequate in all respects and immediately following the reorganization of the National Nurses Association, steps were taken to plan new laws that would meet modern nursing requirements.

On 3 July 1947 Japanese Cabinet Order 124 amended the National Medical Treatment Act pertaining to nurses and established standards of legal registration and licensure of clinical nurses, public health nurses and midwives.

While this amendment served to fit the existing needs, the Nursing Education Council proposed that an entirely new separate nursing law should be made effective. In July 1948 the nursing law was passed by the Diet and provides all necessary legislation to maintain and control nursing standards and education. Applicants for colleges of nursing must have at least 12 years of schooling comprising six years of primary school, three years of lower secondary school and three years of upper secondary school. The law stipulates that clinical nursing courses will be of three years duration and further, that public health nursing and midwifery programs will be on a post-graduate level with graduation from a three year clinical course required. Requirements to be met by school faculties, hospital facilities and practical experience training are also included in this law.

The law is patterned very closely after existing nursing laws in the United States and offers the Japanese nurses every legal essential in establishing a modern nursing profession.

Nurses Aide Program

In January 1948 in coordination with the Surgeons Office, Far East Command, 200 selected Japanese nurses were employed as nurses aides in the 12 United States Army hospitals in Japan. To educate them in modern

nursing techniques they were first given 160 hours of instructions and supervised ward demonstrations, then assigned to regular nurses aide duties. A qualified Japanese nurse was provided each United States Army hospital to assist in the teaching program and also to serve as an interpreter.

Nursing Education Progress

Steady progress has been indicated in the nation-wide nursing program. The interest and enthusiasm displayed by both the nursing students and graduates had been a tremendous help in advancing new ideas and techniques in modern nursing education.

Sponsored by the Educational Committee of the National Nurses Association a series of one month institutes were started in the early part of 1947. These courses consisted of lectures and demonstrations to both instructors and students of colleges of nursing affiliated with a recognized hospital. During the summer of 1947 two institutes, called "Summer School for Nurses and Midwives", were held in Osaka and Hokkaido respectively.

In order to determine whether the existing schools of nursing would be able to meet the requirements of the proposed nursing law, which passed the Diet in July 1948, an extensive survey of schools of nursing, midwifery and health centers was started in April 1947. These surveys, completed in all 46 prefectures, furnished information relative to existing curricula, educational standards, physical facilities, degree of training and determined those schools that would be permitted to continue under the current nursing law. Data obtained from this survey will be used in deciding which colleges of nursing will be granted government recognition.

In connection with the various public health refresher courses, a public health nurses box has been designed and adopted for use in the home visiting program. Diagrams of this box, a list of its contents and technique for use, has been printed in English and Japanese and distributed to all prefectures to be used as a guide for constructing similar boxes in prefectural nursing programs.

In the visual education field a 35 mm. sound film has been made portraying Japanese nurse training and activity. Entitled "Lady of Science", the film depicts the various steps of the nurse's life while undergoing training and also shows the nurse engaging in post-graduate work after completion of a regular three year clinical course. Produced by a Japanese film company, the film has been presented in 25 prefectures to date and most recently to members of the National Diet prior to passage of the nursing law. The picture has primarily been exhibited to young people in upper secondary schools as a means of acquainting them with nursing as a profession.

Recently a second film was made by the Paramount News Company of America concerning nursing activities at the Tokyo Model Demonstration School of Nursing. This was a movie short and has been sent to the United States.

Another important part of the nursing program has been the series of ten day midwifery courses originally planned for ten cities in Japan. Eight of these courses have now been completed with 1,588 midwives having attended. These courses cover the responsibility of the midwife during the entire care of the mother and baby. Copies of all lectures are printed in Japanese in sufficient amounts to give each midwife a set for future reference.

In March and April 1948 an intensive two months study course for nursing instructors was held in the Central Red Cross Hospital in Tokyo. Sponsored jointly by the Ministry of Welfare and the National Nurses

Association, 52 nursing leaders received certificates of completion. The responsibility of the instructor to the students in training, and advanced teaching techniques were carefully demonstrated during this period.

Japanese travel abroad is now permitted for the purpose of cultural or educational study; but subject to a sponsorer who guarantees all financial support (Japanese citizens are not accepted as sponsorers). The Rockefeller Foundation has approved scholarships for four nurses for post-graduate study in nursing and public health methods and administration in four selected American universities. These nurses departed for the United States in July 1948. Other agencies and organizations in the United States have also expressed an interest in sponsoring Japanese travel for specific educational purposes and it is anticipated that in the future a larger number of Japanese nursing personnel will be given an opportunity to share in this program.

The latest completed report (October 1947) indicates that there are 739 existing schools of nursing, both public and private, (includes 52 schools of nursing in Japanese Red Cross Hospitals covered under Chapter 6, Welfare) with a total enrollment of 31,953 students. Licensed graduates total 251,375.

Nursing Literature

Japan's isolation from 1939 until the beginning of the occupation resulted in a stagnation of modern nursing text books, journals and literature. During the early phases of the nursing program most of the material used for the full time and refresher courses was composed by American nursing personnel and translated and published by the Japanese. This was a rather difficult procedure due to the time consuming element and the shortage of paper. It was, therefore, realized that the securing of modern nursing material was essential to effective teaching.

The Ministry of Welfare and several qualified Japanese doctors and nurses have published various nursing literature including a Procedure Manual for Clinical Nurses, the Midwifery Manual, the Manual for Public Health Nurses, Standing Orders for Public Health Nurses, and have adapted and printed a Public Health Nursing Record to be used in recording home visits. A nursing booklet entitled "We Grow Up" (United States Public Health Service Booklet No. 102) has been translated into Japanese and published for the benefit of Japanese nurses.

Various nursing associations and agencies in the United States, who are interested in the nursing program in Japan, have donated a total of 14 copies of text books, journals and other nursing literature, of which 11 copies have been translated into Japanese, published and distributed to the various colleges of nursing and prefectural nursing associations. The remaining gifts are currently being translated and printed.

A recent policy now permits copyright privileges of certain American publications and it is anticipated that within the next six months selected nursing text books will be available for republication in Japanese.

Future Programs

Future programs provide for a continuance of all the regular three year clinical nurse courses and also the refresher courses including post-graduate training, which have proven so beneficial. It is also planned to provide special courses in various hospitals to help prepare the clinical nurses in meeting the requirements of the new nursing law.

The Tokyo Model Demonstration School of Nursing will be continued and under study is the installation of a four year course on public health nursing.

Particular emphasis will be placed on the attaining of scholarships for nurses to study abroad and also to obtain further quantities of modern nursing literature.

The National Nurses Association will continue to be given advisory help in preparing them for recognition among similar associations of other nations.

An important project is the securing of American public health nurses for the 46 prefectures in Japan. American nurses are now assigned to ten prefectural and seven regional areas but the expansion of the nation-wide nursing program makes it essential that additional American personnel be available for supervision and guidance including public health nursing activities in the nation-wide health center program.

Chapter 5

VETERINARY AFFAIRS

Introduction

Under the supervision of the Veterinary Section in the Horse Bureau and the Veterinary Affairs Division of the Agriculture Bureau, Japan's pre-war animal disease eradication programs consisted of Infectious Osteomalacia, Paratyphus of Horses, Tuberculosis of Dairy Cattle, Sterility Control, and Research for Infectious Anemia of Equines. Control was also maintained over veterinary licensure.

During the war veterinary activities were sharply curtailed as the military carried a high priority on animal disease control work being conducted on Japanese Army horses. The production of animal biologicals amounted to over 10,000,000 cc annually of which 80% were requisitioned by the Army. This created an acute shortage for non-military veterinary control.

Meat and milk inspections were carried out solely under prefectural supervision as subsidies from the national level had never been granted. Monthly inspections were made in milk plants but meat inspection was irregular consisting of an occasional visit to slaughter houses.

The emphasis on veterinary activities was placed on the maintenance of health in the horses of the Japanese Army. No Army food inspection was in force.

The Japanese Veterinary Association

One of the first reforms was the reorganization, along democratic principles, of the practically defunct Japan Veterinary Association. New associations were also formed in the prefectures to carry out the national policy. The organization has since taken a leading part in the various veterinary programs.

In the fall of 1946 a Council on Veterinary Affairs was established within the association to plan and promote projects of interest and value to the veterinary profession. This stimulated considerable interest in improving veterinary standards.

Officials and members of the new Japan Veterinary Association have gradually accepted more responsibilities as they gained confidence in themselves. They were encouraged to publish a monthly veterinary journal and in addition have published several booklets on technical subjects for use by veterinary officials.

The association has also assisted in reviving the Society for Prevention of Cruelty to Animals which sponsors the humane handling and disposition of livestock. The society is currently planning to establish the Japanese Kennel Club on an operational basis similar to that of the American Kennel Club.

The Veterinary Education Council

Formed at the same time as the new veterinary association, one of the first steps taken by this council under SCAP guidance was the study of minimum educational standards. Based on their recommendations it was finally agreed that 12 years of preliminary education, consisting of six years primary school, three years lower secondary school and three years upper secondary school be required prior to entrance to the new four year veterinary college course at university level. In addition, the Ministry of Agriculture and Forestry approved their plan for national examinations

for veterinary licensure, the initial examination to be held following the graduation of students from the 1949 class year.

The Veterinary Education Council also assisted in disseminating literature concerning meat and dairy inspection, animal disease control and veterinary education to each of the 46 prefectures in Japan. During the first occupational year the council helped to conduct surveys in 30 prefectures to determine the status of veterinary conditions.

Confronted by a shortage of public health veterinarians trained in modern veterinary standards, a two month refresher course opened at the Institute of Public Health in Tokyo on 9 January 1948. These courses have continued to date, each prefecture being allocated one representative for each course. The council was instrumental in starting this refresher program. In many other ways, they have assisted in elevating veterinary education and standards.

Control of Animal Diseases

After determining that civilian veterinary activities had practically ceased, the Japanese Government was directed to establish measures for the control of animal diseases, submit animal disease reports, submit reports on the manufacture of vaccines and sera, establish measures for the inspection of meat and dairy products, and submit reports on meat and dairy inspections including the testing of dairy cattle for tuberculosis.

Steps were then taken to resume the manufacture of vaccines and serums and other veterinary supplies. At the same time a program was started for maintaining constant surveillance over Japanese officials to insure proper control over animal diseases as well as meat and dairy inspection methods.

These programs continued into 1947 and with the exception of Equine Encephalitis, all outbreaks of animal diseases were controlled. The eradication of Equine Anemia and Bovine Infectious Abortion was stressed and resulted in an acceleration of activity on the part of livestock breeding stations in setting up programs to eliminate these diseases from their breeding stocks.

Tuberculosis tests were completed on two-thirds of the dairy cows in Japan during 1947. Additional tests are currently in progress. A rabies immunization program this same year resulted in 85% of all dogs being immunized.

Recommendations to the Ministry of Agriculture and Forestry led to increased efforts by prefectural poultry farms in eliminating Pullorum disease from their flocks. Animal quarantine stations were reorganized and the facilities improved to adequately handle animals for import and export and conduct laboratory tests on animals during the quarantine period.

In the fall of 1947 several regional conferences, attended by officials from the Ministry of Agriculture and Forestry, resulted in the completion of an emergency plan should disease potentials suddenly reach epidemic proportions or new disease entities be encountered in relation to imports which would require the application of effective control measures.

Control in the production of biologicals was improved with the requirement that all vaccines and serums be assayed. Biological production has steadily increased and in some cases exceed the demand. Some exports have been made.

The nation-wide health center program calls for one public health veterinarian to be assigned to each health center. The selection of personnel for these assignments is proceeding satisfactory and will result in more efficient coordination of veterinary activities in each health center district.

Recently a program was started to make spot area tests throughout Japan to arrive at the approximate percentage of Brucellosis, a relatively new disease, present in the draft and dairy cattle. If a high percentage of reactors are found then a program of either complete eradication for removing the reactors for slaughter or an immunization program will immediately follow.

Regulations pertaining to the Food Sanitation Act, Law No. 233 of 1947, have been approved and are now being implemented by the Ministry of Welfare. Regulations pertaining to animal quarantine inspections have also been recently revised to correspond to those in existence in other countries.

An amendment to Law No. 29, The Prevention of Infectious Disease of Domestic Animals, was passed by the Diet on 29 June and became effective on 20 July 1948. This amendment requires the reporting of all infectious diseases, pays an indemnity not exceeding ¥30,000 when animals are removed for slaughter during disease prevention programs, and requires a health certificate to accompany all animals intended for breeding purposes when shipped between prefectures. Regulations implementing this law have been approved and also include those programs concerned with the eradication of Bovine Tuberculosis and Equine Infectious Anemia.

Inspection and Surveillance

Since the start of the veterinary program constant surveillance and inspections of Japan veterinary officials at national and prefectural levels have been exercised as a means of correcting the deficiencies found to exist. The ante-mortem and post-mortem examination of meat is now being accomplished in all slaughter houses with improvement in the inspection procedures resulting from demonstration and distribution of technical bulletins on this subject. Improved sanitary programs have aided the care in handling of meat in slaughter houses.

The Dairy Score Card and the Dairy Plant Score Card method of inspection, currently used by the United States Public Health Service, was introduced into Japan in November 1946 and is being utilized in all the 46 prefectures. The use of these score cards has had a marked effect in establishing better cooperation between the milk producers and the prefectural inspectors. The standardization of operating methods in the dairy milk plants has been stressed and the Ministry of Welfare has cooperated in obtaining critical laboratory reagents necessary in the improvement of the required testing of milk samples.

Veterinary officials in the Ministries of Welfare and Agriculture and Forestry were encouraged to make more prefectural inspection trips for the purpose of establishing a closer alliance with prefectural officials. Such action stimulated the activation of many programs which previously have received very little attention.

Early in 1948 the sanitary inspection of marine products was inaugurated. In connection with this program a technical bulletin on the subject was distributed to the responsible Ministry of Welfare officials.

Livestock Importation

In order to provide good dairy stock for animal breeding, 25 purebred Holstein bulls arrived in Japan in May 1947, a gift of the Heifers for Relief Committee of the Brethren Society of the United States. The Society has also donated 2,000 goats to Japan, the first shipment arriving in May 1948, with three shipments totalling 775 animals having been received to date. These goats are allocated by the Ministry of Welfare to various institutions as part of a welfare rehabilitation program and are also being allocated to stock various goat farms and agricultural research stations throughout the nation.

Continued assistance has been given Japan veterinary officials on the problem of increasing the milk supply. The problem is directly related to increasing the stock supply and the cost of animal feed-stuffs.

A study revealed that milk is currently the cheaper item, but over a period of several years the importation of cows and goats would produce larger quantities of milk at costs cheaper than the sum required to continue the imports of powdered skim milk.

Future Programs

Future plans provide for a continuation of all the programs currently in force. Improving the qualifications of veterinary personnel and educating them in modern veterinary standards and inspection procedures will be emphasized.

Animal disease control will continue to be stressed with more attention given to prompt detection of all animal disease outbreaks. Tuberculosis testing programs will be expanded, likewise the rabies immunization program.

In the field of veterinary education, future plans consist of placing all educational reforms in operation, establishing a modern circulating library and also implement the new national licensure examination requirements.

As Japans' livestock population was severely depleted during the war, it is planned to introduce new blood-lines for rehabilitation of existing herds and also introduce improved methods in animal husbandry.

The milk supply problem will be partially solved by increasing the cross-breeding of draft and dairy cattle and increasing the goat population.

These overall plans will be supplemented by the publication of technical bulletins covering various phases of veterinary programs to be used as references and guides for Japan veterinary officials.

Chapter 6

WELFARE

Public AssistanceIntroduction

Relief work in Japan prior to the Tokugawa period (Ante 1603 A.D.) was carried on by the voluntary charity of the Emperor, the occasional "mercy" of Buddhist monks, the custom of mutual support by members of the same family (the family system) and the traditional spirit of mutual help among neighbors.

Relief legislation had been sketchy and patchwork in character. In contrast to the Christian concept of the worth and dignity of the individual, the Japanese followed the Confucian doctrine in the five human relationships: (1) subjects to their Prince, (2) children to their parents, (3) wives to their husbands, (4) younger brothers to their elder brothers, and (5) neighbor to neighbor. No responsibility or obligation was extended to the stranger. (See Chart No. 17).

While such a system might work in a simple agricultural society, by the middle of the 19th century a succession of rice riots by a hungry populace brought on the restoration of the Emperors. It may be considered that the indirect cause of the collapse of the shogunate and the emergence of the Imperial family (1863-1868) was the failure of the Tokugawas to provide for the needs of those unable to care for themselves.

The industrial booms and resultant depressions following the Sino-Japanese, Russo-Japanese, and the First World War forced the government to take measures in providing for the indigent worker during periods of sickness and unemployment. The cabinet evidently had an eye to the fate of the shogunate in 1860-1868.

In 1874 the first relief law was passed. It was a legislative endorsement of the old family and neighborhood responsibility idea and avoided the meeting of relief needs by the government. From 1890 until 1929 attempts were made to introduce and secure an adequate poor relief law in every session of the Diet but each time met the opposition of the reactionary industrialists then in power. They maintained that such legislation "would encourage idleness". A relief law passed in 1929 and effective in 1932 made no impression on the overall problem as no funds were appropriated to carry out the provisions of the law.

While the government was making only a half-hearted advance in the welfare field, the efforts of Christian missions in appealing for individual rights finally stung the Buddhist elements into joining action at their side. In 1918 there were 92 public and 1,255 private welfare institutions which ranged from insane asylums to rescue homes for prostitutes.

In the field of industrial protection the first factory workers law movement started in 1882, but legislation was not passed until 1911, becoming effective in 1916. Rice riots in 1918 forced more beneficent legislation in the labor field.

Laws chiefly concerned with relief at the time of the Occupation were the Poor Relief Law, Military Aid Law, Protection of Mothers and Children Law, and the War Sufferers Relief and Medical Protection Law. These were administered by the Ministry of Welfare through local government welfare agencies upon certification mainly by Homen-iin (Volunteer District Welfare Commissioners appointed by Prefectural Governors) numbering some 80,000 throughout the nation. Relief was also handled

by volunteer or private organizations receiving support largely from government subsidies and gifts from large corporations. During the war however, all relief activities were disorganized and limited in their benefits.

The abrupt end of the war and the result of the final phase of aerial bombings left the Japanese Government and people in a state of shock, wholly unprepared to meet the emergency problems of health, food and shelter. Functional government had broken down and the Japanese people were undecided as to what was expected of them.

Daily Life Security Law

It was realized that immediate action was necessary to provide a reserve supply of food and clothing to be used for relief needs in emergencies. This was accomplished by the seizing of former Japanese Army and Navy stock-piles of food and requiring the Japanese Government to warehouse these foods and hold them for distribution upon orders of SCAP. This food stock amounted to more than 30,000 tons of biscuits and canned goods.

Japanese Army and Navy clothing stocks were also taken into allied custody and held for relief as needed. At designated periods these supplies were released to the Japanese people when food and clothing in normal governmental channels was no longer to be had. In addition to the food supplies attained from former Japanese Army and Navy stock piles, 100,000 tons of wheat were imported from the United States as a relief reserve.

One of the first directives issued by SCAP in the relief field was "Relief for Hiroshima" in which approximately 12 tons of medical supplies were dispatched to the International Red Cross delegate in Hiroshima for use in the relief of Japanese persons injured by the atomic bomb.

On 8 December 1945, SCAPIN 404 directed the Japanese Government to submit a plan for meeting the relief needs of the people during January to June 1946, estimating the number in need of relief, and providing necessary legislation. On 31 December the Government advised SCAP of their plans for a comprehensive relief law to be administered by a quasi-official agency. A limit of ¥200 was proposed as the maximum grant per month for families of five. Eight million persons were estimated to be in need of relief. (Later reports revealed the case load to be 2,500,000). This plan, as submitted by the Japanese Government, was unacceptable to SCAP as it delegated to a quasi-official agency administration of the relief program for the nation.

On 27 February 1946, SCAPIN 775 was issued directing the Japanese Government to establish a single national government agency which, through prefectural and local governmental channels, would provide adequate food, clothing, shelter and medical care equally to all indigent persons without discrimination or preferential treatment. An additional provision was added that "within the amount necessary to prevent hardships, no limitation to be placed on the amount of relief furnished".

The subsequent plan as submitted by the Japanese Government was acceptable and resulted in the birth of a modern public assistance program with passage by the Diet of the Daily Life Security Law which became effective 1 October 1946. The law is modern and complete. Thus the Japanese Government became one of the few governments of the world who accepted responsibility for the relief needs of its people.

The Daily Life Security Law:

1. Established government responsibility for providing adequate assistance to needy persons equally without discrimination or preferential treatment.

2. Defined the roll of governmental agencies and public and private institutions.
3. Provided expenses for food, fuel, clothing, housing, medical care, occupation aid and funeral aid to needy persons.
4. Specified financial participation of all governmental levels with the central government bearing the larger share of the costs.

Since passage of this law several nation-wide increases in the family budget have occurred. Increases have been based upon increases in the cost of living as well as a desire on the part of the Japanese Government to provide for minimum standard of living for those in need. Sanitary conditions, food and medical care have been immeasurably improved. (See Chart No. 18).

One of the weaknesses in the Japanese Government welfare administration has been the lack of field supervision. This is true of all levels of government. The recent inauguration of a limited field supervisory staff of seven field representatives in the Ministry of Welfare is a proper step in the right direction. Several prefectures have also inaugurated similar programs. (See Chart No. 19).

During the past few months a standing committee, authorized by the Ministry of Welfare, has been attempting to set up a basic standard of requirements for families and individuals upon which family allowances may be based. Delays in release of official rations and delays in release of public assistance allowances make pricing of a standard of requirements extremely difficult and thus limits the effectiveness of the use of such figures for standard family allowances for public assistance.

All former Japanese Army and Navy food stocks have now been released. A small quantity of the clothing stocks are still being warehoused, distribution having been made periodically to meet relief requirements especially during the winter season.

In February 1948 a nation-wide review of public assistance recipients was completed. The review was based on a desire to redetermine the eligibility of current recipients and the need for training welfare workers, (Minsei-iin) and prefectural and local officials. It was supervised by central and prefectural government officials who used the procedure as a practical training experiment. The review, however, resulted in both increases and decreases in individual family allowances and in the removal of ineligible families from public assistance rolls.

Public assistance totals in persons and money reflect a decrease in recipients and an increase in expenditures since passage of the Daily Life Security Law. Indicated below are figures for May 1948 with figures for May 1947 shown for purposes of comparison. (See Chart No. 20).

	<u>May 1948</u>	<u>May 1947</u>
Persons- Institutional	136,898	126,052
Persons - Non-institutional	<u>1,911,666</u>	<u>2,637,281</u>
Total	2,048,564	2,763,333
Assistance in Cash	¥377,359,593	¥208,811,628
Assistance in Kind	<u>35,361,528</u>	<u>26,219,215</u>
	¥412,721,121	¥235,030,843

Future Plans

Future plans include the preparation of new public assistance statistical procedures so that information assembled will be of value in social planning, in granting of public assistance funds, and to reflect accurately the total public assistance needs of the nation.

Attention will also be given to the evaluation, strengthening and revision of present fiscal policies and procedures of the Ministry of Welfare including the prefectures, to afford factual data on which to determine accurately and quickly the money requirements of prefectures, cities, towns and villages for public assistance purposes, and to maintain adequate controls over all expenditure of such funds.

A further project calls for a revision and strengthening of administrative procedures and policies concerning public assistance with emphasis on the procedures in application, approval or rejection, review of need, and the development of model forms necessary for local operational activities.

Future plans also include the development of in-service training programs for welfare commissioners (Minsei-iin) and full-time welfare personnel employed in national, prefectural and local welfare programs. Legislation to provide an adequate legal basis for the work of the welfare commissioner will also be undertaken; this to include the development of standards and procedures for the appointment of welfare personnel in prefectural and local offices.

RepatriationIntroduction

At the close of the war almost 7,000,000 repatriates were awaiting repatriation to Japan. This presented a gigantic absorption problem even in normal times and was made extremely difficult due to the economic collapse following the termination of hostilities.

Processing

In addition to the medical processing of repatriates which is covered under Chapter 2, Preventive Medicine (Port Quarantine), the Japanese Government provided a number of programs designated to meet the welfare needs of these persons.

At the repatriation center, activities included the exchanging of money in a sum not to exceed ¥1,000 and the issuance of a Certificate of Repatriation. Free room and meals were provided and a free ticket to the repatriate's destination was furnished including sufficient food for five days, clothing and bedding if needed, plus a gratis issue of ¥500 if the repatriate was without funds. Repatriates were also given free medical care including hospitalization, if authorized by the repatriation center doctor.

Enroute from the repatriation center to the place of destination, the national and local governments coordinated in providing places of rest, feeding, and medical treatment in the stations along the route.

To date, approximately 6,000,000 persons from Korea, China, Dutch East Indies, Formosa, United States, Canada, Australia and the islands of the South Pacific have been returned to Japan. There are approximately 650,000 repatriates in Sakhalin, Siberia, Southeast Asia and Manchuria to be repatriated; the majority being in Russian-held territories. An average of 15,000 to 20,000 are currently arriving at the repatriation centers each week.

Governmental Assistance

Japanese Governmental programs for "war sufferers and repatriates" include a number of special projects designed to meet the needs of not only those made homeless by the war but also for the millions of returning civilians, many of whom had never been in their home country. Repatriates come under the provisions of SCAPIN 775 (Public Assistance) and receive the same care and treatment as other Japanese citizens.

When the repatriate reaches his selected place of residence he secures work in his profession or trade either through the local employment bureau or through his family. If nothing is available locally, he is advised of the location of work and assisted in reaching it.

In those cases where the repatriate cannot find employment or is unable to care for himself or his family, he receives care under the provisions of the Daily Life Security Law and in addition receives cooking and household equipment, ration cards, sufficient relief funds to purchase food and a free but limited issue of clothing. Distribution varies from prefecture to prefecture dependent in part upon local resources. Through the local Social Affairs Offices, housing is provided by the utilization of former factories, barracks and warehouses or similar large unused structures. At the current time however, only 15% of the people repatriated are so housed, the remainder having secured shelter by "doubling up" with relatives and friends.

Business loans not in excess of ¥5,000 are available through the people's banks for use in establishing small business enterprises or in the purchase of small tools. These loans draw no interest for one year, 6% for the next four years and are due and payable at the end of five years. Applications have exceeded the ¥1,600,000 loan fund and demands are currently being made for additional funds, a larger loan limit, and longer terms.

Repatriates desiring to settle on land may purchase acreage through the Ministry of Agriculture and Forestry. They may borrow up to ¥10,000 for this purpose or rent land and borrow from the Ministry for farm tools, equipment, seed, and fertilizers. This permits a total of ¥15,000 in loans from the Ministry of Agriculture and Forestry and the people's banks that can be available to these repatriates.

Upon returning to his place of residence the repatriate presents his Certificate of Repatriation and returns to full citizenship. Certain residence laws will not permit voting until he has lived in his ward or ku for six months, although this law has been suspended from time to time to permit large groups to exercise their franchise. The repatriate who wishes to stand for office however, may do so the day he returns by filing his candidacy.

Special attention is given to the repatriate by the licensing officials in that they give priority to those desiring to open small businesses.

Future Programs

No special programs are contemplated with the exception of endeavoring to secure larger funds and longer terms for repatriation loans. No other specific projects are indicated. The program has been operating satisfactorily with many of the activities scheduled to cease upon return of the remaining repatriates.

Population ControlIntroduction

During the final stage of the war 93 major cities in Japan were partially destroyed by air raids. Great segments of the population, particularly women and children, were evacuated to rural areas. As soon as hostilities were terminated, many people began a general return to the urban centers. This posed a serious problem as housing was from 40 to 80% destroyed in these various cities, food distribution was limited, communications were meager and faulty, and sanitation was in disrepair. To allow general return to the devastated cities of some 7,000,000 or 8,000,000 persons would threaten famine, plague, and disaster to a government struggling to restore some semblance of normality.

Also recalled was Japan's former experience in that rice riots would be an early incident and would lead to widespread rioting and general disorder. Establishing soup kitchens, field sanitation and hospital services would be the usual procedure to meet this situation but it would also be the beginning of a chain of emergency stop-gaps that would be all too difficult to terminate at a later date.

Law Concerning Population Movement

On 8 January 1946 the Japanese Government was directed to submit a plan indicating measures to be taken to restrict or prohibit unnecessary population movements from rural to urban centers (cities of 100,000 or more people).

A subsequent Ministry of Welfare Ordinance provided that before a person could move from a rural area it must be established that he had housing in the urban area and that his services were needed in the Japanese economy. After this was proven, a "permit to move" was given by the local officials and his ration card transferred to the urban area. Without this permit no rations were made available to the individual.

This Ordinance originally was effective for only a given period of time and it was therefore necessary to extend the provision of the directive from time to time.

In November 1947 the Japanese Diet was presented a bill by the Home Ministry on "Control of Public Movements" and on 22 December 1947 approved the bill which became Home Ministry Law No. 221. This bill carries all the provisions of the former Ministry of Welfare Ordinance but continues to restrict the movement of Japanese people from rural to urban areas until 31 December 1948.

As result of the measures that have been taken, refugee massing in the larger cities has been prevented, soup kitchens have been avoided and order has been maintained. Disease, suffering, and distress has been kept to a minimum. The restrictions have also resulted in many former urban dwellers settling in the rural areas permanently.

Foreign NationalsIntroduction

At the beginning of the occupation, foreign nationals numbered 2,000,000 Koreans, 30,000 Formosans and Chinese and 7,500 various other nationalities.

Monetary relief to foreign nationals was not required, but to prevent malnutrition it was necessary to supplement their diet to bring it above the normal Japanese standard. The enemy national problem was further

aggravated because the funds of the Germans were blocked and their movements restricted to meet security requirements. No jobs were available; neither were there funds to purchase these supplemental rations. About 545 of these foreign families were German women and children from the Dutch East Indies and their plight would have been critical had not some form of relief measures been undertaken.

Relief and Care

Several directives to the Japanese Government required that they provide, regularly, supplementary rations for all resident nationals of the United Nations, neutral nations and stateless persons. The enemy foreign nationals have been made the responsibility of the Japanese Government to provide the essentials to meet the minimum standards of health and welfare. The Japanese Government's plan for relief in kind was approved and as a result no enemy nationals were forced to go without the daily necessities of life.

These basic policies established during the occupation have been sound and at no time has there been general suffering among the foreign national group. On 9 January 1948 SCAP further implemented this policy as it relates to food, by issuing SCAPIN No. 1841 thereby assimilating into the same care and treatment as provided for foreign nationals, the same care and treatment henceforth to be rendered to former occidental enemy nationals.

This action was necessary because certain former enemy nationals had exhausted their reserve stocks of food and from physiological needs were in need of the same rations as other occidentals. This implementation had the effect of restoring to a small group some semblance of normalcy and at the same time obviated discriminatory treatment because of nationality background.

Of these foreign nationals who were residents in Japan at the time of the surrender, approximately 600,000 Koreans out of the original group have elected to remain in Japan and receive the same care and treatment as Japanese citizens. Chinese-Formosans and other foreign national groups have been given opportunities for repatriation however, very few persons in these categories have elected to be repatriated.

Housing

Introduction

Prior to World War II it was estimated that Japan had 14,000,000 homes which included structures of all types of construction, from modern cement and wood buildings to the typical style Japanese wood and straw buildings. At the end of hostilities some 4,500,000 homes have been destroyed through bombings, fires, and natural catastrophies. As the nation had diverted its efforts to war time requirements, no new building construction had been undertaken; consequently, a serious housing deficiency existed.

Board of Reconstruction

The Board of Reconstruction was established early in 1946 and was made responsible for the surveying of housing needs and making available essential materials based on these surveys. It authorizes all building permits and as of 1 August 1946 such permits for all Japan have been controlled at the national level. Under this coordinated program an average of 23,000 homes are being built in Japan each month.

Building Progress

The lack of materials as well as funds has not permitted a wide expansion of this building program without endangering the Japanese economy. Progress however, has been steady even though natural catastrophies such as the earthquake and flood in Okayama prefecture and Shikoku region areas in 1946, the Kanto region flood in September 1947, and the Fukui earthquake disaster in July 1948, resulted in further housing shortages.

Currently underway in Tokyo is a demonstration housing project consisting of two units, 600 homes each, which are being erected in burnt out areas in Akibane Ward. The buildings were purchased from Army surplus stocks and consist of prefabricated houses, size approximately 12 x 14 feet. Plans provide for making these houses available to war victims, repatriates and returned ex-service personnel.

The project will have playgrounds for the children, public baths, will be landscaped and will also be provided with adequate sanitation.

Future Plans

Future plans consist of a continuance of current programs with emphasis on the possibility of expanding building construction as fast as the Japanese economy will permit. Careful surveillance is maintained over this program to insure that all projects are being carried out satisfactorily.

Licensed Agencies for Relief in Asia (LARA)Introduction

Early recognition by SCAP of the need for a single channel through which to funnel all donated relief supplies coming to Japan from the United States and other countries resulted in an agreement with interested organizations and the inauguration of LARA. On 30 August 1946 SCAPIN No. 1169 directed the Japanese Government to accept, warehouse, account for security, and distribute relief goods shipped to Japan which had been donated by groups, individuals and volunteer agencies in America making up the LARA organization. Under the SCAP-LARA agreement the Japanese Government assumed all costs from dock to distribution under the general supervision of SCAP. LARA was authorized to ship up to 2,000 tons per month. Their primary plan of operations is to raise the caloric intake of persons in institutions, orphanages, hospitals, and sanatoriums by supplementing the food received in the official Japanese rations.

Relief Shipments

The first shipment of LARA relief goods arrived in Japan 30 November 1946 consisting of 350 tons of food and clothing. As of 1 June 1948, 72 shipments have been received totalling 4,726.32 tons as follows:

Food	3,519.81 tons
Clothing and shoes	1,054.04 "
Medicine	59.34 "
Miscellaneous	93.13 "

In addition to these relief supplies the LARA organization is being used to ship 2,000 goats to Japan, a gift of the Heifers for Relief Committee of the Brethren Society. The first shipment arrived in May 1948, with three such shipments totalling 775 animals having arrived to date.

The goats are being used to increase the livestock population, thereby increasing milk production, to stock goat farms and research agricultural

stations and also as a welfare rehabilitation project in which allocation of the animals is being made to various welfare institutions throughout the nation.

LARA maintains three representatives in Japan who supervise the receipt, storage, and distribution of each shipment, exercise surveillance over the allocation of the relief goods and render reports to the Public Health and Welfare Section. All goods are distributed through official Japanese Government welfare channels.

Assistance Rendered

The relief afforded to the Japanese through LARA shipments has been of material assistance and includes the following programs:

1. Food, clothing, and medicines have been distributed to 1,750 public and private welfare agencies, the majority of which are institutions engaged in child care. Over 1,500,000 inmates and patients are receiving a share of the benefits from this institutional relief distribution.
2. LARA has supplemented the School Lunch Program which was inaugurated in January 1947. This supplementary feeding program has contributed to raising the health standards of Japanese school children.
3. Made available 320 tons of food and 750 bales of clothing supplies to assist in meeting the emergency needs of disaster sufferers throughout the serious flood in the Kanto region during September 1947. Particularly helpful were the supplies of powdered milk and baby food for children and infant feeding during this emergency period.
4. Furnished emergency food, clothing and established milk stations in the current relief and rehabilitation program for Fukui and Ishikawa Prefectures as a result of the earthquake disaster on 28 June 1948.

Thousands of letters have been received from recipients of this program thanking SCAP and LARA for the benefits which have resulted and expressing hope that it will continue to function. It is anticipated that the need for LARA relief goods will continue for at least one or two more years.

The Japanese Red Cross

Introduction

The Japanese Red Cross was regarded as the second greatest Red Cross society in the world. Its organization was not dissimilar to that of the American Red Cross but in function it followed the European pattern with special emphasis placed on a nation-wide system of hospitals, clinics, sanatoria and schools of nursing. Prior to World War II the society, by Imperial Ordinance, was placed under the control of the Sanitary Commission of both the Army and the Navy. The wartime Red Cross program, therefore, was geared to the war effort and its pre-war activities were measurably altered to meet military demands.

Reorganization

On 20 September 1945 the American Red Cross was invited to assist Public Health and Welfare Section, SCAP in reorganizing the Japanese Red Cross society along democratic lines with primary emphasis on serving the civilian health and welfare needs of the Japanese people.

Like other indigenous agencies during the first months of the Occupation the Japanese Red Cross went through the stages of shock and confusion preceding its initial efforts at reactivation and reorganization. Personnel were immediately screened at national and chapter levels and many of the wartime leaders were found objectionable and subsequently dismissed. Under the temporary leadership of acting officials, national reorganization proceeded slowly. Recruitment of new and competent personnel was difficult and the society was further handicapped because of the lack of sufficient funds for payment of salaries. Personnel recruited were unfamiliar with Red Cross activities and lacked knowledge and confidence in undertaking their responsibility.

The formalization of new statutes approved by SCAP and the Japanese Government in December 1946, and adopted by the society in January 1947, provided for the complete separation of the society from Government. While the Empress remained a patron of the society, the new statutes provided a democratic basis of organization and function by which the society could develop programs and services needed by the people of Japan.

Principles of Red Cross organization and function as defined by the International League of Red Cross Societies were also incorporated in the new statutes.

Concurrently with its reorganization the society faced the task of reactivation and continuation of basic Red Cross services programs. Efforts were initially directed to hospital and medical services activities. While many of the hospitals and clinics were totally or partially destroyed during the war, medical and clinical services to the civilian population were continued and in many communities afforded the only medical facilities available. In all, 41 general hospitals were placed in operation together with four maternity hospitals and ten tuberculosis sanatoria. Thirty-four clinics, many of them caring for up to 50 bed patients, were also activated. Approval was obtained for the release of frozen funds with which to finance necessary repair and reconstruction of these facilities, particularly in communities where Red Cross provided the only medical service available.

Expansion of the Red Cross Program

Election of officers under the new statutes took place in January 1947 and it was not until then that the Society's legal reorganization could be considered complete. With the election of its new officers, the Society for the first time began to express sound aggressive leadership. Assistance of American Red Cross consultants resulted in plans being initiated for the reorganization of its principle services, including Junior Red Cross, disaster relief and nursing services.

In Junior Red Cross, a new and inexperienced staff was oriented in the principles of the International Junior Red Cross movement and significant progress was made in activating plans for new and effective activities in schools throughout the nation.

The earthquake and tidal wave disaster of 21 December 1946 in Okayama Prefecture and the Shikoku region of Japan gave the Japanese Red Cross an excellent opportunity to demonstrate its traditional role in time of disaster; namely, providing emergency medical and nursing services to disaster victims. Following this disaster intensive work was accomplished in developing plans for more extensive responsibilities for disaster relief services.

The reorganization of nursing services made a significant advance with the appointment of a nurse as Chief of Nursing Education, the first time a nurse has held this position in the Japanese Red Cross Society.

Five percent of all nurses in training in Japan are enrolled in the Japanese Red Cross Schools of Nursing; therefore, the significance of this appointment to the nursing profession is readily apparent. Under the guidance of an American Red Cross consultant on nursing services, the society has established home nursing programs throughout the 46 prefectures in Japan, fashioned after the American Red Cross Home Nursing Course.

In addition to the programs enumerated in the preceding paragraphs, attention has been given to the development of such services as water safety and first aid, volunteer services, and public relations and information. Because of the lack of specialized consultant service, comprehensive assistance could not be given the society until the fall of 1947.

The New Society

During the first two years of the Occupation the reorganization and expansion of Japanese Red Cross services were completed sufficiently to permit the Society to assume additional responsibility toward the Japanese people.

Modern concepts of publicity and fund raising were introduced to the Red Cross for the first time during a membership and fund raising campaign conducted in October and November 1947. While only ¥142,024,580 or 47.3% was raised toward the goal of 300 million yen, the campaign was successful in many respects and provided experience upon which a more effective fund raising organization will be perfected for the coming drive scheduled for October 1948.

Under the provisions of the National Disaster Law enacted in December 1947 and subsequent agreements with the Ministry of Welfare, the Red Cross was given the responsibility for the administration of disaster medical and nursing services and for the coordination of all non-governmental relief or welfare agencies in time of disaster. The Fukui earthquake disaster in June 1948 gave the Society another opportunity to demonstrate its ability in this respect and they discharged their duties in commendable fashion.

The plan for the reorganization of the Junior Red Cross program was approved and introduced to prefectural Red Cross and Japanese educational officials at a series of regional orientation meetings. Implementation of this program is now underway. In April 1948 a Junior Red Cross Handbook was published and distributed to Japanese school authorities.

Training courses for instructors in the first section of the new Red Cross Home Nursing program have now been completed in seven of the nine regional areas in Japan. This program has been favorably received in the first classes consisting of lay people.

Substantial agreement has been reached concerning the development of a Volunteer Services Program and for its implementation from national to community levels. Likewise, agreement has been reached concerning the essential organizational steps necessary for the general implement of Red Cross services in branches and sub-branches, including towns and villages.

The national system of Red Cross hospitals, sanatoria, clinics and dispensaries has been closely integrated with the progressive developments noted in the medical services and treatment fields in Japan through July 1948.

The reorganization of the Japanese Red Cross and its place among the International League of Red Cross Societies is receiving proper recognition. At the request of the International Organization, SCAP approved a representative (observer) from the Public Health and Welfare Section and

three Japanese Red Cross officials (to act only as technical advisors to the SCAP observer) to attend the International Red Cross Conference at Stockholm, Sweden in August 1948.

Future Plans

All of the current programs will be continued with necessary supervision and assistance furnished to ultimately permit the Japanese Red Cross to take their place among the international family of Red Cross nations.

Child Welfare

Introduction

Child welfare as defined in a modern welfare program, was practically unknown to the Japanese. During the first year of the occupation little progress was accomplished in providing for homeless persons, orphans and waifs. Constant prodding of the Japanese Government by SCAP began to show results in late 1946. A real effort was then made to corral wandering children and provide homes for them but the project was necessarily slow and difficult.

Additional child welfare institutions were required and better trained personnel were needed. Food, clothing and medical care were difficult to obtain with the result that the maintenance of children in institutions became a major problem.

The Children's Bureau

This problem led both SCAP and the Japanese Government to the conclusion that it was of sufficient importance to establish a Children's Bureau within the Ministry of Welfare. Subsequently established on 15 March 1947, the Bureau consisted of three sections: Planning Section, Foster Home Section and Maternal and Child Health Section.

Existing laws effecting children did not provide for sufficient child protection. In order to give the Children's Bureau a real foundation on which to operate it was proposed that a new bill be drawn up to provide the necessary legal framework for a modern child welfare law.

The visit of the late Rt. Rev. Monsignor E. J. Flanagan of Boy's Town, Nebraska, in the spring of 1947, stimulated considerable interest in the children's problems and drew public support of the need for a new law.

To round out the children's program completely it was decided that a fourth section was necessary in the Children's Bureau. The Bureau is now organized as follows:

1. Planning Section
2. Child Protection Section
3. Child Care Section
4. Maternal and Child Health Section

A particular point of interest occurred upon the reorganization of the Children's Bureau when a woman graduate of the New York School of Social Work was appointed Chief of the new Child Care Section. She is the first woman to hold such a position in the Ministry of Welfare.

Following the national plan of a separate bureau for children, prefectures were legally authorized and encouraged to set up a Children's Section

within the Prefectural Welfare Department. Although personnel for these assignments constitute a problem, the prefectures in Japan are endeavoring to complete children's sections as rapidly as possible.

The Public Health and Welfare Section cooperated with the Public Safety Division of G-2 in their drafting of a proposed Juvenile Court Law and a Reformatory Law, both passed by the Diet in June 1948. The Children's Bureau is vitally interested in the provisions of this law as they may relate to child welfare problems.

The Child Welfare Law

The Child Welfare Law was passed by the Diet on 1 January 1948. Certain provisions became immediately effective, the remaining portions of the law were effective 1 April 1948. Following is a brief summary of its provisions:

1. The law points out that the national and local public bodies as well as parents and guardians are responsible for the healthy growth of children.
2. Establishes national and prefectural Child Welfare Boards to study the needs of children and advise welfare officials of these needs.
3. Provides for the employment of child welfare workers for the promotion of the welfare of children and the welfare of expectant and nursing mothers.
4. Provides for the establishing of prefectural child welfare stations, or centers, for the purpose of child study for proper placement, consultative service, health examinations and guidance, and for other problems.
5. Provides for a maternal and child health program with free service for those unable to pay. Urges expectant and nursing mothers to take advantage of such service. Provides additional food and other necessary supplies for expectant and nursing mothers. Provides obstetrical service in "lying-in" agencies.
6. Provides care and protection for neglected or abused children.
7. Provides for a foster home program.
8. Protects children from exploitation and prevents certain occupations harmful to children.
9. Offers matching funds to prefectural and local governments for provision of and operation of children's institutions.
10. Provides for licensing, minimum standards, and periodic inspections of children's institutions.
11. Provides for appeals on local decisions.
12. Provides for protecting individual rights by punishing those who reveal confidential information.

The Child Welfare Law also authorized the employment of 621 full-time paid child welfare workers in the various prefectures in Japan. The

prefectures are currently in the process of hiring these people and marks the first time in Japan's history that full-time, paid governmental welfare workers have been so employed. They are operating in conjunction with volunteer welfare workers (Minsei-iin) and also act as consultants in children's problems and in the problems of pregnant and nursing mothers.

In accordance with the provisions of the Child Welfare Law, the Ministry of Welfare developed a plan for the reappointment of all welfare commissioners, (volunteer welfare workers, Minsei-iin). Approximately 130,000 commissioners have been reappointed since the program began in February 1948. The purpose of the reappointment program is to secure welfare workers who are qualified to assume their additional responsibilities under the Child Welfare Law and to eliminate those who have not been discharging their duties in a satisfactory manner.

Future Plans

The project of primary importance is the supervision and guidance of all the programs which have followed the passage of the Child Welfare Law. These programs are new and will be kept under close surveillance to determine that all provisions are being met.

Another proposed plan is a study of children now in institutions with a view toward segregation of the mentally deficient, psychopathic and the more seriously delinquent children from the normal children. It is also planned to promote a foster home program as an adjunct to present institutional child care programs.

The School Lunch Program

Introduction

School feeding programs were in vogue in Japan as early as 1880 but it was not until 1929 that the school lunch program, instigated by private social work agencies in the larger cities, began to assume some importance.

In 1929, 204 schools carried out a supplementary school lunch program with an average of 21,600 children being daily provided with a school lunch. Total expenditures during 1929 amounted to 30,000 yen.

In 1935 it was determined that an increasing number of children were doing without their midday lunch due to the economic depression. To meet the dietary deficiencies of children of the low income groups the Ministry of Education provided a subsidy of ¥800,000 to assist the local school authorities in providing midday meals for needy school children. This was the first positive indication on the part of the national government of its interest in a school feeding project.

In 1940 after some preliminary study it was decided, in conjunction with the educational system, to provide a supplementary midday meal for children found to be suffering from malnutrition. Physical examinations revealed that children suffering from malnutrition were found in well-to-do families as often as in needy families. While the children of a family of adequate income received a sufficient quantity of food, due to polished rice being the main component of the diet, the child very frequently showed indications of malnutrition due to the lack of other needed nutrients, protein and vitamins B, C, D and K.

From the time of the China incident in 1937 until the termination of World War II, less and less was being accomplished for the children in need of additional nutrients and by the termination of hostilities the school lunch program had ceased to exist.

At the beginning of the Occupation the food picture in Japan was so grim that procurement of food for a school lunch program appeared to be impossible although it was recognized that there was a great need for it. Nutritional surveys made in the spring of 1946, and continued every three months thereafter, indicated the greatest need among school children existed in the large urban areas, particularly Tokyo, Yokohama, Osaka, Kobe, Kure, Kyoto and Fukuoka.

A member of the Hoover Food Commission that visited Japan in the spring of 1946 indicated interest in the redevelopment of the School Lunch Program and gave valuable suggestions as to how the program might be re-instated. In June 1946 interested SCAP officials further discussed the redevelopment of this program.

Sources of Supply

Difficulties relative to food and fuel procurement and the acquiring of cooking utensils were great but by December 1946 they were largely overcome and permitted the program to be inaugurated during this month in which approximately one quarter of a million children in the Tokyo-Yokohama area were initially included. Food supplies were obtained through release of former Japanese Army-Navy supplies, from indigenous Japanese sources and some imports. LARA (Licensed Agency for Relief in Asia) also contributed to this program, supplying a good share of the powdered milk requirements.

In addition to foodstuffs which have been increased as fast as supplies can be obtained, an allocation of 10,000 tons of coal, lignite and wood was made available for the quarterly period of April, May and June 1948, to meet the general deficit in fuel as reported by individual schools and prefectures. To afford a supply of building materials for the construction of kitchen ranges and cooking facilities, also for limited area flooring, an allocation of 63,000 sacks of cement was made to permit a minimum acceptable standard of sanitation.

Administration

The program is administered by the Ministry of Education in cooperation with the Ministry of Welfare. Nutritional consultant service is supplied by SCAP but in general the Japanese government has now accepted full responsibility for operational control. Participation of children of needy families has been made possible through adjustments in grants under the provisions of the Daily Life Security Law.

Originally providing from two to five midday lunches per week to some 251,000 school children, the program has continuously been expanded until now 5,000,000 school children are receiving benefits. The average cost has been ¥3 per child per day.

While the school lunch program has grown as fast as food supplies have permitted, there has been a simultaneous development of voluntary programs particularly in the rural areas. It is estimated that 600,000 children are being given midday school lunches without the assistance of the national government.

All cities of Japan, 200 in number, are now included in the school lunch program in addition to many rural and mountain towns and villages where, by nutritional surveys, it was determined that a deficiency in protein and other nutrients was evidenced (total of 6,599 schools). The following figures indicate the expansion of the school lunch program by month:

Official Program by Ministry of Education

Dec. 1946	251,829
Jan. 1947	2,052,882
Feb. 1947	2,835,943
Mar. 1947	2,906,921
Apr. 1947	2,974,268
May 1947	2,974,268
Jun. 1947	3,057,872
Jul. 1947	2,942,877
Aug. 1947	262,970
Sep. 1947	2,986,877
Oct. 1947	2,908,396
Nov. 1947	4,092,879
Dec. 1947	4,137,975
Jan. 1948	4,443,260
Feb. 1948	4,443,260
Mar. 1948	4,443,260
Apr. 1948	4,652,670
May 1948	4,835,000
Jun. 1948	5,000,000 (Est)

Evaluation of the Program

A study made in 11 prefectures of 33 urban and rural schools indicates a definite weight increase among children included in the School Lunch Program. (See Chart Nos. 21 and 22). Types of menus provided vary, dependent in part on the local availability of fish and fresh vegetables, but the general average has been 250 calories per day and the servings have averaged three to five times per week. The United States Department of Agriculture states that one pound of imported powdered skim milk from the United States, in nine pints of water, will afford 18 servings of milk, each serving totalling 180 cc. This milk may be served as a drink or it may be included in soup, the nutritional value being the same in either case. In many areas it has been found desirable to include the milk in a soup as it provides the central hot dish around which to build the other components of the lunch.

Future Plans

It is the object of SCAP to have the School Lunch Program increased to five meals per week for every school day of the year and to raise the caloric content to 600 calories per individual school lunch. Representation has been made to appropriate authorities that a sufficient supply of basic food be included in the import program to expand the school lunch project to include the 16,000,000 children of compulsory school age (first through ninth grades). The ultimate realization of this goal will be dependent upon improvement in the nation's food situation.

Disaster ReliefIntroduction

In exploring Japanese plans for the protection of the civilian population against frequently occurring fires, floods, earthquakes, and other natural disasters, it was discovered that few prefectures had provided for such emergencies. The laws that were in existence were weak and lacked provisions for finance, direction and coordination.

The total expenditure by the Japanese government for disaster operations during 1930 to 1933 inclusive (latest available figures) amounted to ¥3,844,443.

Early in the Occupation, Military Government Teams had been directed to set up plans for the protection of army personnel and their dependents in the event of disaster. Military Government welfare officers were in the process of strengthening prefectural planning when, on 21 December 1946, a large scale earthquake and tidal wave occurred which affected 14 prefectures. Difficulties experienced during this disaster focussed attention on the fact that coordination at government level was lacking.

The National Disaster Law

As a result of the December 1946 earthquake a proposed national disaster plan was drawn up. After several months of study, to determine the best means of implementing this plan, it was finally submitted to the Diet and became Public Law No. 118 on 18 October 1947.

The National Disaster Law is based on the acceptance of responsibility by the government in the event of a major disaster. It provides for monetary responsibility by both national and prefectural governments. The law provides for a National Disaster Board headed by the Prime Minister and including all Cabinet Ministers. Also included on the Board are the President of the Japanese Red Cross and competent citizens from the various prefectures in Japan.

The Board is responsible for formulating plans of operations and direction in the event of disaster; also to expedite the flow of disaster supplies.

The Law further provides for Prefectural Disaster Boards which have now prepared prefectural disaster plans. Each prefecture is required to have disaster operating teams composed of police, health officials, welfare officials, economic officials, firemen and engineers. The Japanese Red Cross is recognized as a quasi-governmental agency in times of disaster and is responsible for the coordination of all voluntary groups or agencies.

Since the passage of the National Disaster Law the Japanese government (national and prefectural) has expended a total of ¥522,239,313 for disaster relief, of which amount the prefectural governments have contributed ¥121,723,761. The Law has proven its workability in several minor disasters that have occurred to date and the people of Japan have benefited by this modern disaster Law. Japan is the only nation having a disaster relief program wherein a government accepts full responsibility for the total relief of its people in time of a major disaster. During the recent Fukui earthquake the implementation of national and prefectural disaster plans was prompt and efficient and was the cause of favorable comment from many sources. Disaster teams from the surrounding prefectures rushed aid to the stricken area immediately following notification of the earthquake and with the Japanese Red Cross coordinating the volunteer agencies, problems of food, clothing, medical supplies and medical treatment were handled efficiently.

In this nation where natural disasters are frequent and serious the National Disaster Law will be implemented many times to aid the needy and unfortunate.

Cooperative Agency for Relief in Europe and the Far East (CARE)

Outline of the Program

The CARE Program has been operating in Europe since 1946. Some 17 European countries have received benefits from this program by being the recipients of approximately 5,000,000 food and clothing packages that had been distributed to individuals in need of relief. CARE is a non-profit organization through which individuals, agencies, societies and similar

groups make remittances to CARE Inc., New York City, in the amount of \$10.00 for each package unit they are desirous of having delivered to an individual or welfare organization. There are several types of CARE package units, namely food, clothing, woolen goods, cotton goods, blankets, medical and infant care.

On 21 August 1947 SCAP authorized CARE to extend their operations to Japan. The first shipment arrived in Yokohama on 10 July 1948 and totaled 9,982 packages. Distribution of these packages began on 19 July and is currently continuing.

At the present time only food packages will be received in Japan. This is a specially prepared package called the "Oriental Pack", consisting of 23 pounds of food suitable to oriental tastes. Each package contains approximately 30,000 to 35,000 calories depending upon the availability of certain food items included in the package.

CARE packages enter Japan tax and duty free and the recipients are not subject to any reduction in their regular authorized official food rations.

One of the important features of the CARE Program is that each donor must designate a specified recipient with the donor later receiving a form signed by the recipient showing that delivery was made. Necessary operating expenses of the CARE Program are covered by the cost of the package. Delivery of the packages in Japan is being made by Japanese government postal channels.

Social Work Education and Training

Introduction

The lack of qualified social workers in the Ministry of Welfare as well as in prefectures, cities, towns and villages was a limiting factor in the development of a sound public and private welfare program. In order to improve this situation the Ministry of Welfare was advised to establish more adequate in-service training programs for persons already employed. A second approach was the establishment of formal educational programs in colleges, universities, and separate schools for persons intending to enter social service work.

The Japan School of Social Work

This school was established in November 1946 under the joint sponsorship of the Ministry of Welfare and the Japan Social Work Association. A one-year course of study is offered for more advanced students while a three-year course is available for younger students. Assistance has been given the school in establishing an adequate curriculum including provisions for field work training. Students from two one-year courses have now been graduated with the third one-year course currently in process. The second freshman class of students to the three-year course was enrolled in April 1948. Surveys have revealed that 95% of these students who have graduated from the one-year courses have secured employment in public or private welfare agencies.

Attempts to expand the school's program were retarded by the lack of adequate housing and library facilities. This situation has been remedied by acquiring the former Naval Museum Building in Tokyo. The name of the building was changed to the Central Social Affairs Hall and besides housing the Japan School of Social Work, it houses the national office of the Welfare Commissioners' Federation and the Japan Social Work Association, including their library and the Social Work Institute.

In-service Training Programs

An in-service training program consisting of eight one-week institutes was established early in 1947. Approximately 50 persons, representing each surrounding prefecture, attended these institutes which were held in eight of the nine regional areas in Japan.

This program was financed by the Ministry of Welfare and conducted under the joint sponsorship of the Ministry, the Japan Social Work Association, and the Japan School of Social Work. This program definitely aided the administration of social welfare projects.

Social Work Education

During July and August 1947 a series of meetings were held in Tokyo to consider the matter of social work education in Japan. These meetings were attended by representatives of various social welfare agencies and colleges and universities interested in this subject. A report containing recommendations and standards was prepared and submitted to the Ministries of Education and Welfare as well as other interested organizations and individuals.

As a result of this activity the Japan Social Work Education Committee was established to continue study and analysis of these problems.

During the first three days of October 1947, a National Social Work Assembly was held in Tokyo under the sponsorship of various national social work agencies. Delegates from all parts of Japan attended as well as national officials of the government including the Emperor and Empress. This assembly was held in recognition of the first year of operation of the Daily Life Security Law and the inauguration of the Community Chest.

Confronted by the necessity of improving personnel standards in public and private welfare agencies in the Osaka, Kyoto and Kobe areas in Japan, a meeting called by the Governor of Osaka Prefecture in September 1947 resulted in the establishment of the Kansai Social Work Education Committee. This committee consisted of representatives of social welfare agencies and educational institutes in the Kansai area of Japan. They meet each month to consider problems related to education and training for welfare personnel.

Thirteen colleges and universities in this area have completed plans to expand their course of study in the social sciences in order to give a more adequate academic basis for students planning to enter the social service field upon graduation. Based on recommendations that a branch of the Japan School of Social Work in Tokyo be established in Osaka, in order that more students from that area may secure at least one year of study of social work, plans were developed to grant this request and are currently being implemented.

Future Plans

Emphasis will be placed on the establishment of social work education programs in colleges and universities in order to provide more adequate academic training for persons intending to enter the social work field.

Present programs will also be continued and expanded with necessary supervision and guidance from SCAP's social work personnel.

Rehabilitation of the Physically HandicappedIntroduction

This is one of the more recent welfare programs. On 10 February 1948 the Japanese government submitted a plan for the care of approximately

500,000 persons in Japan that were physically handicapped by reason of injury, serious illness, loss of sight and other causes, including war, bombings, natural disaster and industrial accidents. Among this number, some 324,622 were estimated to be ex-service personnel.

Initiating the Program

The program was accepted by SCAP on 18 February 1948 provided that it operated on the basis that aid given would be non-preferential and non-discriminatory. This program, designed to rehabilitate the physically handicapped by instilling a will to work and overcome their problems, was inaugurated in Tokyo on 6 June 1948 with the opening of the first institution for such handicapped persons. Included in the current course are 56 ex-service personnel and 23 civilians. Most of the cases are amputees, therefore, hospital services are being provided at a nearby national hospital. Such trades are being taught as shoe repairing, tailoring, wood craftsmanship, etc.

The program will shortly be established in nine prefectures of Japan in which 12 institutions have been selected for the accomodation of approximately 2,000 persons.

Future Plans

This program being new, future plans provide for close supervision and guidance over the projects currently in effect to insure that they will be carried out to a successful conclusion. Additional institutions will be made available to expand the program.

Community Chest

Organization and Purpose

The constitutional prohibition against governmental subsidization of private welfare agencies and operations, together with the break-up of the "Zaibatsu" and the loss of the source of private donations to private welfare activities, forced the private agencies to appeal to the government for help and counsel in planning programs for private agency fund raising. A national committee, similar in purpose to the Community Chest in America, was organized to develop broad plans and programs of fund raising at prefectural level.

The Initial Fund Raising Campaign

The organization of a National Fund Raising Committee for the financing of recognized private welfare agencies was established during the summer of 1947. Fund drives which occurred in the winter of 1947 were preceded by a nation-wide appeal through the press, radio and other media in which an effort was made to secure the participation of every adult in Japan.

This national campaign was held between the dates of 25 November and 25 December 1947.

This was the first such campaign ever attempted in Japan. The national goal was set at ¥678,200,000 with each participating prefecture having a quota to attain. Due to the serious Kanto regional flood in September 1947, four prefectures which suffered heavy damages did not participate. The remaining 42 prefectures however, raised a total of ¥571,071,681 or 84.2% of the national goal. This was a very commendable effort for the first such campaign ever conducted in the nation.

Future Plans

It is planned to have a joint Community Chest and Red Cross fund raising campaign during the fall of 1948. Based on experiences obtained

from the previous campaigns, it is believed that a larger membership will be possible in the coming drive. Plans have been worked out jointly by the two societies for sharing a proportionate part of the amount raised. It was also agreed that subsequent campaigns in the future years would be handled independently. Considerable interest is currently being stimulated for the second nation-wide effort.

Chapter 7

SOCIAL SECURITY

Introduction

Since 1871 the Japanese had developed programs furnishing some form of social insurance protection to most of the population. In 1945 there were more than 10,900 local insurance associations in addition to the national organizations and agencies administering the five major social insurance programs. Approximately 68,000,000 individuals had some form of protection.

No provision for unemployment insurance existed for any group. Except for government employees, there was no true workmen's accident compensation insurance. The Employers' Liability Insurance primarily imposed liability upon employers within certain limitations and provided for a fund from which employers could be reimbursed after they had provided medical care or paid out small lump sum benefits.

The legal framework of Japan's social insurance for other than public employees was of relatively recent date. Compulsory health insurance for industrial workers and miners, although introduced in 1922, was not put into operation until 1927 and in its initial form was very limited in scope and social value. Even more restricted in coverage and in the level of benefits was the Employers' Liability Insurance against employees' industrial accidents, established in 1931.

Modern Japan in the field of social insurance, as in many other fields, took over western institutions without accepting their basic philosophies. The paternalistic authoritarian character of the Japanese regime had definitely influenced its social insurance program. Although laws provided for unpaid prefectural committees to hear appeals under the social insurance programs, there were no records of any appeals having been made, few people knew that such committees existed and, in many cases, committees had not even convened for the purpose of organizing.

The Five Major Programs**--Health (Sickness) Insurance (1922)-- (See Chart No. 23)**

This was a compulsory system for employees of industrial, mining, commercial and transportation concerns employing five or more and with contributions divided equally between employer and employee. This insurance provided for both occupational and non-occupational illnesses and accidents, paying cash benefits during brief incapacitation and also providing for medical care, maternity care and funeral expenses. An average of 6.4 million workers plus 12.9 million dependents were covered.

--Employers' Liability Insurance (1931)--

Legislation defining and placing upon the employer in civil engineering, construction and forestry industries responsibility for occupational accidents and illnesses; providing for employer-supported reserve funds from which the employer was reimbursed for medical care, cash benefits for sickness and continuing invalidity (lump sums), funeral and survivors. Estimated coverage 1.25 million workers.

--National Health Insurance (1938)--

A program extending the health insurance system and sponsoring voluntarily organized town and village health associations, which are supported by members' contributions and a government subsidy, providing medical and maternity care and, in some instances, funeral benefits to the rural population and self-employed individuals. Coverage of family heads and their dependents estimated at 41 million persons.

--Seamen's Insurance (1939)--

A composite social insurance program for seamen serving on vessels of twenty tons or more, with contributions divided between ship owners and seamen; providing for both occupational and non-occupational illnesses and accidents, paying cash benefits for sickness and continuing invalidity, funeral and survivors, in addition to old age and medical care. The program covered 92,000 seamen.

--Welfare Pension Insurance (1941--formerly "Workers' Annuity")--

This is a compulsory system of practically the same employees as are covered by health insurance, with contributions divided equally between employer and employee; paying old age benefits (beginning in 1956) and cash benefits for continuing invalidity and survivors related to both occupational and non-occupational disabilities. Coverage averaged 6.4 million workers.

Government Protection Systems

--Government Pension System (1871)--

A retirement law for all national and prefectural officials in a career status (including policemen and teachers); financed primarily by the government (over 97%); paying cash benefits for occupational invalidity, old age and survivors. Approximately 700,000 civilian employees plus 1.1 million military personnel were protected.

--Workmen's Compensation for Government Employees (1892)--

A program based on three Imperial Ordinances (No. 80 of 1892, No. 382 of 1918, and No. 109 of 1928) and financed by government funds for all national and prefectural employees, including officials, not covered by Government Enterprise Mutual Aid Societies; paying cash benefits for funeral and survivors and for occupational disabilities; also provides medical care and pays short-term cash benefits for sickness. Coverage of 1.4 million employees.

--Government Mutual Aid Societies (1907)--

Government Personnel (10 Societies); organizations composed of national and prefectural employees, including officials, not covered by Government Enterprise Mutual Aid, and financed equally by the government and employees; providing medical and maternity care and paying cash benefits for confinement and funeral and, for occupational disabilities and short-term sickness. Coverage estimated at 328,000 employees plus 735,000 dependents.

Government Enterprise (11 Societies); organizations composed of government employees, excluding officials, working in government monopolies, and financed equally by the government and employees; for both occupational and

non-occupational accidents and illnesses; paying cash benefits for brief incapacitation, confinement, old age, funeral and survivors, and also providing medical and maternity care. Coverage of 1.5 million employees plus an estimated 3.4 million dependents.

Post Office Insurance and Annuities

--Protection and Coverage--

The Japanese also had a system of Post Office Insurance and Annuities, administered by the Ministry of Communication. This program gave protection comparable to United States life, endowment or retirement commercial insurance policies and provided for death benefits, old age and limited disability. Over 91 million policies have been issued, having a face value of more than 26 billion yen.

Development of the Program

The Labor Advisory Committee to SCAP

The Social Insurance Bureau of the Ministry of Welfare was initially directed to submit current statistics on coverage, contributions, benefits paid into reserve funds and related services. In reviewing this data, it was apparent that contributions paid before the end of hostilities far exceeded benefit grants under any of the programs and that the social insurance programs had been used to partially defray the expenses of the war.

Shortly thereafter, a Labor Advisory Committee to SCAP included in its report a review of the social insurances systems and recommended that the following steps be taken:

1. Keep the social insurances alive during the period of currency inflation.
2. Adopt specific measures affecting Health Insurance and National Health Insurance to assure adequate medical treatment.
3. Assure a broader participation by insured people and other groups concerned in the management of these social insurances.
4. Study the need for unemployment insurance and for a separate system providing indemnity and medical care for those disabled because of occupationally caused accidents or illnesses.
5. Assure the development of a program of information and education with regard to social insurances to insure that beneficiaries will be familiar with their rights under existing systems.
6. Study the extension of coverage on those groups not insured under existing programs.

This Committee, finding a serious lack of coordination in existing programs and problems susceptible to treatment only in terms of revisions in the program, expressed the view that a comprehensive reform of social insurance could and should be undertaken and that such action should be taken immediately.

In May 1946 a Social Security Division was established in the Public Health and Welfare Section to carry out the recommendations of the Labor Advisory Committee.

The Committee for the Investigation of Social Insurances

This Committee was established by the Japanese Cabinet in March 1946 with membership drawn from labor, employers, faculties of leading universities and officials of the Japanese Government, for the purpose of improving the social insurances, particularly the various federations of health insurance and national health insurance associations. In joint conferences with this Committee, in which representatives of the Japan Medical Association were in attendance, all problems and proposed solutions were carefully analyzed with emphasis on the ability of the Japanese economy to meet any suggested changes.

Improvement of Existing Programs

Pending the development of a unified, comprehensive insurance program, the Ministry of Welfare, in the interim, was advised the following recommendations should receive immediate attention:

1. Establishment of an informational and educational program for the insured.
2. Establishment of a system of reports covering statistical and financial information.
3. Initiation of a program of research and analysis.
4. Development of a plan for the utilization of the Welfare Pension reserve fund.
5. Study of the possibilities of revising the eligible age for receiving pension benefits.
6. Development of a supervisory plan for assuring proper administration of the various systems from the national to the prefectural and local level.
7. Study of the possibilities of unifying the health provisions of the various systems into one national health insurance program.

Pending a general reorganization of the social security programs, assistance was given the Ministry of Welfare in the preparation of new legislation and amendments to existing laws.

The national health insurance system has suffered seriously because of inadequate and unsound financing. The Ministry of Welfare was given guidance in its endeavors to obtain increased national subsidies to rebuild the national health insurance medical facilities. The Ministry also was encouraged to make more effective use of existing hospital and clinical facilities and drug supplies, and to improve procedures for paying doctors, to assure that adequate medical care would be provided for all insured people.

Through a Cabinet decision in March 1947, a program of separation allowances, financed by government funds, was set up for all public employees except those assigned to the Occupation Forces. Estimated total of 1.9 million were involved. Cash benefits were provided for loss of employment and, on the death of a worker, for his survivors.

Amendments to Insurance Laws

Based upon the provisions of the Labor Standards Law, Workmen's Accident Compensation Insurance was developed in cooperation with the Labor Division of the Economic and Scientific Section of SCAP and became effective 1 September 1947. This replaced the Employers' Liability Insurance Act. Coverage is

estimated at 6 million and extends generally to concerns employing five or more persons, but includes undertakings in certain hazardous occupations employing only one worker. Government workers and seamen are excluded.

The Health Insurance Law was amended to remove the distinction between provisions for occupational and non-occupational disabilities and exclude claims met by Workmen's Compensation Insurance. The Welfare Pension Law was similarly revised to remove the distinction between provisions for occupational and non-occupational disabilities and to exclude, for the period (six year maximum), claims compensated under Workmen's Compensation.

The Seamen's Insurance Law was amended to assure compliance with the workmen's accident compensation provisions of the new Mariners' (Labor Standards) Law, comparable to the Workmen's Compensation Insurance Law for land workers, and coverage was more than doubled through extending protection to all seamen on ships of five tons or more.

Other important changes made in existing legislation and ordinances to make them conform to the spirit of the new constitution include:

1. Establishment of advisory committees.
2. Adoption of a more adequate wage rate as a basis for calculating benefits.
3. Reduction in the length of time required for individuals to qualify for benefits.
4. Elimination of clauses which would deny benefits if the claimant was guilty of contributing to the negligence causing his disability.
5. Liberalization of the system for gaining a fair hearing on disputed claims.
6. In connection with benefits payable to survivors, provisions were made for more equality among family survivors, eliminating the traditional special inheritance rights of senior male survivors.

Assistance was also given in the revision of the laws of established mutual aid societies for government workers. Laws were amended to extend coverage to practically all workers, thereby eliminating inconsistencies and complexities in an effort to coordinate their activities into one adequate and efficient system.

The unemployment allowances and insurance laws, also developed in cooperation with the Labor Division of Economic and Scientific Section of SCAP, became effective 1 November 1947. These revisions included workers in firms of five or more, employees of industries, except shipping, construction, agriculture and domestic services. Coverage is now estimated at 6.5 million. The Seamen's Insurance Law was revised to incorporate similar unemployment provisions for seamen.

Ceilings on taxable wages under several of the programs were raised in order to equalize the burden among the insured, take a more realistic view of the current economy, and approach a standard for the various programs. Amendments introduced in the Diet in April 1948 provide for substantial increases in existing and future invalidity and survivor benefits and additional benefits for the survivors spouse and children.

Regulations prescribing appeals procedures have now been completed, including Ministry of Welfare instructions to the prefectural offices. A referee has been appointed in each prefecture to hear appeals under the Health, Welfare Pension and Seamen's Insurances, and central appeals boards have been appointed for each of these programs to receive appeals from the referees' decisions. Prefectural Appeals boards have also been formed to conduct hearings under national health insurance. Referees were assigned the collateral duty of conducting information services to acquaint the public with the right of appeal.

In July 1948 Diet action transferred substantive features of the social insurance programs from Cabinet and Ministerial Ordinances to Statutes. At the same time the comprehensive revision of the National Health Insurance Law, assigning basic responsibility to the local public bodies for the administration of pre-paid medical care for those residents not otherwise protected, was completed. This amendment represents the results of research and planning by the Ministry of Welfare in conjunction with representative advisory bodies prompted by the continuing difficulties this program has had to contend with since the closing days of the war. Emphasizing the community character of the program, the amendments should provide a firmer basis for its operation.

Unification of the Reporting System

In order to improve social security operational statistics and reporting in regard to both their adequacy and timeliness, the Insurance Bureau of the Ministry of Welfare was assisted in overhauling and expanding current requirements. Japanese officials were given a list of data on which periodical reports were to be henceforth submitted to serve as a basis for a unified reporting program.

The Social Security Mission

The Social Security Mission from the United States arrived in Japan in September 1947 to complete a study of existing social security legislation and administrative practices in Japan, for the purpose of making recommendations to improve the social insurance and medical care benefits for the Japanese people.

The Mission spent ninety days in Japan during which time a series of conferences were held with the Japanese Committee for the Investigation of Social Insurance, Japanese Government officials, representatives of the Japan Medical Association, representatives of Japanese industry, workers and professions, and with representatives of various social insurance systems. During this period, visits were made to various insurance institutions, as well as public and private institutions which were caring for patients under provisions of the social insurance systems, in order to get a complete picture of the overall program throughout the nation.

In connection with the visit of this Mission, extensive research was undertaken regarding the economical and financial status of Japanese social security programs. Studies were completed on the statistical analysis of the past experience of social insurance schemes now operating, as well as actuarial and cost estimates of the future burden of selected programs under varying assumptions of coverage, scope, etc.

Their report, which has been reviewed and analyzed by various interested SCAP sections, was accepted by SCAP on 3 July 1948, and turned over to the Japanese government for use as a document of reference and study in strengthening current social insurance programs. Several recommendations in the report have already become law, among these being the recently passed Health Center Law, the Medical Service Law and the Immunization Law.

Other recommendations, included the establishment of an advisory council to the Diet and administrative agencies on planning policies and legislation; integration of all present obligatory social insurances into one basic system to provide uniform protection; and a strengthening of health insurance for other than wage earners by providing community health plans at the choice of the citizens. The Report further recommends that reforms be patterned to Japanese needs and cautioned the danger of attempting to copy existing programs in other nations without consideration of the basic differences in these nations' social structures.

Future Plans

When an agreement is concluded on the framework of an adequate, coordinated and soundly financed social security program, efforts will be directed along two main lines: (1) implementation of the plan through appropriate legislation and ordinances, and (2) surveillance of the administration by the Japanese Government agencies of the social insurance programs to insure they are carried out effectively and efficiently.

Sound administrative procedures seem to be a special need in the Japanese Government agencies. In implementing the Japanese social insurance program, special attention will have to be given to the following:

1. Adequate information to insured people as to their rights and obligations, under the law.
2. Extension of the scope, authority and public representation on committees established by the government for advisory and review purposes.
3. Administrative supervision of operations from the national as well as from the prefectural level. The government will need an adequate and qualified field force. The process of supervision will include statistical reporting and standardization of procedures to assure complete and effective control.
4. Coordination and cooperation between the government insurance officials and the Medical Association in raising the standards of medical services to the insured.
5. Acceptance and exercise of responsibility in the local areas of government.
6. A simplified and non-partisan method for more use of appeal privileges to assure proper administration and greater individual participation in the program.

Economic trends in employment, wages, national income and production will have to be carefully evaluated in the light of their effect on the reasonableness of the social insurance provisions for compensation of wage loss, adequacy of provisions for paying the costs of medical services, the adequacy of the provisions for financing the system and of existing reserves. Continued evaluation will also have to be made of the outlook for changes in major economic indices, as a guide to action needed to preserve the program.

Chapter 8

Nutrition

Japanese Food ConsumptionPre-surrender Analysis

Historically, Japan has always had a food deficiency. With a population now of 80,200,000 (est. 1 July 48) and limited areas for production (only 16% arable), she has been dependent on food imports amounting to at least 15% of her requirements. The diet is basically composed of rice, fish and fresh seasonal vegetables.

The war did not create problems in nutrition but only emphasized the inadequacy of the indigenous food supply, consequently the curtailment of imports and the shortages of the necessary food nutrients are directly related to the health of the civilian population.

During the war with China and later World War II, the Japanese people were on a restricted ration diet which became more severe as the war progressed and imports were curtailed. The military had saved and stored large quantities of foodstuffs for their food requirements, leaving the civilian population deficient in their normal food rations.

The inadequacy of the ration was partially met by home gardening. Surveys indicated that the children of cities had been underfed resulting in lowered height and weight compared with the years previous to 1941.

The resultant confusion of the capitulation caused a disorganization of the existing ration system; lack of transportation prevented adequate distribution of the meager food supplies available.

Nutrition SurveysIntroduction

An accurate appraisal of the Japanese food situation was dependent upon data concerning the nutritional status of the population and information as to the actual food consumption. As the official ration level was, and still is, below the minimum subsistence level, it was anticipated that consumers would supplement ration issues by home production, gifts and purchases of non-rationed food.

A SCAP directive to the Japanese Government required nutrition surveys to be conducted in Tokyo starting December 1945. In February 1946 the cities of Nagoya, Osaka, Kyoto and Fukuoka were added. Sapporo, Sendai, Kanazawa and Matsuyama were added in May 1946. In addition, an equal number of people were surveyed in the rural areas of the prefectures surrounding these cities.

These initial nutrition surveys then covered Tokyo, eight large cities and 27 prefectures. They were conducted every three months and have been so conducted to date (February, May, August and November).

The surveys also include physical examinations for purposive sampling of the communities for certain symptoms associated with nutritional deficiency, including body weights and heights. In addition, the food consumption was obtained on one-half of the people given physical examinations.

The total number of individuals examined every three months has averaged about 150,000, including surveys conducted through November 1947.

This represents approximately 1% of the population in these designated areas who are representative of all age groups and all economic groups. These same individuals have been included in each survey conducted during the course of the calendar year.

The results are considered reliable, having been comparable from survey to survey. (See Chart No. 24).

The Results of the Surveys

Variations in food intake resulting from the seasonal availability of indigenous food crops are shown by the nutrition surveys. In the fall and winter months following the harvest of the rice and sweet potato crops, the consumption has risen, while during the summer months food intake falls off sharply with the depletion of stocks of staple foodstuffs.

The per capita caloric intake in Tokyo in December 1945 of 1,971 calories largely was the result of consistently high consumption of sweet potatoes during the fall months. The production of sweet potatoes, which yield very high food values per unit of land, has been expanded considerably in recent years but, due to the limited processing and storage facilities, difficulty is experienced in attempting to store sweet potatoes beyond January.

The nutrition surveys conducted in the four cities in February 1946 indicated a much lower food intake than had prevailed in Tokyo during December. Tokyo was not included in the February survey.

The subsequent nutrition surveys in May, which included the eight cities and Tokyo, indicated a definite decrease in food consumption for Tokyo largely as result of the curtailment in ration distribution at that time. There was a slight decrease in caloric consumption for the cities surveyed in May which had been included in the previous February survey.

The August 1946 survey indicated an improvement in the city of Tokyo because the staple food ration was supported with imported food. The caloric consumption in the eight cities continued to decrease, 1,567 calories, and in four of the large cities fell to approximately 1,300 calories. This decrease in food intake in August was due to a curtailment in the ration distribution which had been largely confined to Tokyo and the other major deficient areas in May, but became widespread throughout the nation in July and August as indicated on Chart No. 24.

In November 1946 the caloric intake increased in all cities with the harvest of the rice and sweet potato crop. In February 1947 the caloric intake was slightly lowered due to the gradual depletion of food stocks from the previous fall harvest.

The nutritional surveys in May 1947 indicated a substantial drop in food intake reflecting the curtailment in ration distribution in certain areas and the reduced availability of food supplies from home gardening and black market sources. The nutrition data and the amounts of various classes of food consumed show the extent to which the Japanese depend upon grain products and roots for their energy and the very meager quantities of animal protein and soy beans available for their diet. Also indicated is the very low sugar and fat in their diet.

The rural areas have lived, in relation to normal consumption, at a moderately low but uniform food intake level throughout the year. There was a definite increase in caloric intake in November 1946 directly related, as with the cities, to the sweet potato crop. The quantity of

grain products was not increased in November even though available to the farmer. February 1947 nutritional surveys showed a slight decrease in caloric intake.

The results of the physical examinations of the population indicated a change in the proportion of individuals with symptoms associated with nutritional deficiencies during the worst period of food restriction. In May there were slight increases in individuals with anemia, loss of knee jerk and bradycardia in both cities and rural areas. These symptoms are often associated with a deficiency of the vitamin B complex.

There is a seasonal drop in the vitamin B¹ content of rice and the lack of supplemental goods, including vegetables, during the winter may have been as much a cause of the increase in physical symptoms as the decreased food supply.

Since May 1946 the nutritional surveys have indicated an increase in the number of individuals with symptoms related to nutritional deficiencies, particularly with reference to weight loss. The result of the weighings indicates that there was a rather high percentage of young children and individuals over 30 years whose body weights were at least 10% less than the standard weight. In August there was a general increase in the percentage of individuals in all age groups whose body weights were at least 10% less than the standard weight. The results in November compared similarly to the data obtained in May.

In an effort to secure more extensive information on the nutritional status and the food consumed by the Japanese people, nutrition survey plans were revised beginning February 1948. (See Chart No. 25). The new plan covers a random sampling of the civilian population as against the previous method of selecting individuals who were periodically surveyed during each survey made for the calendar year. Included in the present system is Tokyo, eleven large cities (Sapporo, Sendai, Yokohama, Nagoya, Kyoto, Kanazawa, Osaka, Kobe, Kure, Fukuoka and Matsuyama), all other cities with a population of 30,000 or over, in addition to the rural areas of the entire 46 prefectures. Therefore, the attached chart shows the nutritional surveys broken down into 4 main columnary headings, Tokyo, 11 large cities, other cities (population over 30,000) and the 46 prefectures.

During the May 1948 surveys, the second under the new revised plan, a distinction was made in both the urban and rural areas between the farming and non-farming groups. The higher caloric intake of the first group, as indicated in Chart No. 26, is due to the food retention allowances permitted the farmers. The definite increase in the amount of animal protein consumed over that of the February 1948 surveys can be attributed to the continued efforts being made to increase the flow of fish through official distribution channels.

Physical examinations show an increase in the proportion of individuals having symptoms associated with nutritional deficiencies during the May 1948 surveys. Individuals in both cities and rural areas had increases in anemia, edema, loss of knee jerk and bradycardia. As indicated in previous surveys, these deficiencies are attributed to lack of vitamin B complex.

Nutritional deficiencies of the Japanese population are also the result of the inadequacy of certain essential nutrients in their diet as well as their dependence upon cereal foods.

Use of Imported Foods

The Japanese people having been on a limited food consumption for a period of at least seven years are showing, as a result, the mental let-

hargy and inability to carry out prolonged physical labor characteristic of chronic malnutrition. A study made on the labor output in relation to food consumption among coal miners indicated that the tonnage per miner dropped from 14 tons per day to 5.3 tons per day as the caloric intake decreased.

Surveys conducted on children in the schools has shown retarded growth, both in height and weight as compared to normal standards of height and weight in relation to age.

Imports of food, therefore, have been necessary to raise the caloric intake of the Japanese people to a minimum subsistence level as well as to prevent the possibility of disease and unrest.

The use of imported food however, presented new and difficult problems to the Japanese as at times it has been necessary to issue soy flour, corn flour, wheat flour, milo and currently sugar as the main staple food for families for periods of a week or more. The issuing of food in forms heretofore unknown to the Oriental taste has required a revision in the methods of preparation in cooking, as compared to rice, and the use of more fuel which is still in short supply.

The Japanese Government has undertaken an extensive consumer education program to insure that the people unfamiliar with imported foods can efficiently utilize these rations. Japanese nutritionists have experimented with these foods and subsequently prepared educational information for the civilian population. The radio, magazines, newspapers and other media are being used to reach the Japanese housewives. Nutritionists in the health centers as well as those employed in the various prefectures are also participating in this educational program by giving lectures and practical demonstrations in their respective areas.

The School Lunch Program

The school lunch program was started in December 1946 as a result of nutrition surveys indicating that school children were particularly deficient in animal protein, calcium and riboflavin. Originally serving 251,829 children, the program has now been expanded until 5,000,000 (est.) children are included in the nation-wide school lunch feeding project. The ultimate goal is to expand the program to reach approximately 16 million children of compulsory school age (first through ninth grades). However, this is strictly dependent upon the ability to secure necessary supplies for the program which in turn is partly dependent upon the availability of food imports.

Nutritional studies have been regularly conducted on children in the school lunch program and definite increased in body weights and heights have been indicated.

Note: For complete information on this nation-wide project, refer to Chapter 6, Welfare (The School Lunch Program).

The National Food and Nutrition Council

This council, reorganized in December 1946, consists of not more than 30 members and includes the Prime Minister as President in addition to representatives of the various ministries of the government concerned with food and nutrition problems. Also included are private individuals technically trained and experienced in food, agriculture, education, public health and economic affairs.

The council holds regular meetings to discuss the overall nutrition problems of the nation and has been very helpful in speeding up ration distribution and in eliminating certain administrative irregularities in the ration plan.

The National Institute of Nutrition

The National Institute of Nutrition, which is under the supervision of the Ministry of Welfare, was organized in the fall of 1947. On 8 June 1948, however, it was given new prominence by its establishment in a new building completely equipped with facilities for nutritional research. The advisory board of the National Institute of Nutrition includes individuals trained and experienced in agriculture and food processing. A branch experimental station for various agriculture experiments related to nutrition is located in Chiba prefecture.

The Institute has now started experiments on timely nutritional projects and they are expected to contribute toward the solution of the many nutritional problems now confronting the nation.

The Japanese Nutritionists Association

This association was reorganized in May 1946 and its current membership of 2,800 members is restricted to licensed nutritionists. The association has as its main purpose the improvement of nutrition standards in Japan. The nutritionists' bill, passed by the Diet on 10 November 1947, requires nutritionists to be graduates of specialized schools of nutrition prior to licensing. This has aided the association by setting up nutrition education standards.

Future Plans

On 15 June 1948 the first nutrition refresher course was completed at the Institute of Public Health in Tokyo, from which 38 nutritionists representing the various prefectures in Japan received certificates. This course was of two months' duration and current plans provide for conducting four such courses each year, each new class to begin the month following the conduction of the national nutrition surveys. This, therefore, will permit nutritionists from each of the prefectures to participate in these refresher courses.

Nutritionists are being employed in the various health centers throughout the nation and as a means of furthering nutritional education, a two weeks' nutrition refresher course was conducted in the model health center in Tokyo to acquaint these appointees with their duties prior to being given permanent assignments in one of the nation-wide health centers.

The necessity of conducting nutrition surveys every three months is recognized. No changes are contemplated in the present procedures. As long as there exists a need for imported food, continued efforts will be made to educate the civilian population on the various methods of preparation of such food to permit full utilization of their nutritional value.

Chapter 9

SUPPLY

ProductionIntroduction

The pharmaceutical industry, developed in Japan, had carried out an extensive export trade throughout the Orient. Although of questionable quality, surgical instruments, x-ray equipment and other hospital supplies and equipment had been produced, mainly in small plants on an assembly basis.

During the war, the medical and allied industries suffered heavy losses. Approximately 50% of the factories engaged in the manufacture of medical supplies and equipment had been destroyed or converted to production of war materials. Due to the lack of raw materials and the deterioration of equipment, the remaining factories were producing only 20% of pre-war requirements.

The government had assumed rigid control over all medical supply and equipment production, purchasing the bulk of the products for their armed forces. This resulted in the civilian population receiving a very small share of these critical items.

No medical supplies had been distributed by the Japanese Government since June 1945. The quantities distributed had gradually diminished as the war progressed and were entirely inadequate during its later stages.

Production and distribution was exercised through a series of control associations and companies each of whom handled a certain commodity group. These organizations operated on a commercial basis with the government assuming no financial responsibility for economic control. Although it was a basic policy to delegate control to industries, the officials of control organizations were appointed by the government and operated under strict governmental supervision.

Control associations purchased the entire production of manufacturers and conducted a wholesale operation through sales to corresponding control companies in each prefecture. This served to disrupt distribution through normal distribution channels and resulted in the creation of a bottleneck.

The Ministry of Welfare was responsible for the manufacture and distribution of medical supplies and equipment, but had never been given sufficient authority to carry out this responsibility. Other ministries controlled the allocation of raw materials and did not feel obligated to follow recommendations of the Ministry of Welfare concerning allocations to medical supply and equipment industries.

One of the outstanding operational deficiencies noted was the failure to arrive at any determination of actual requirements as a guide in allocating raw materials and scheduling production. There was no comprehensive plan for production control.

At the beginning of the Occupation, manufacturing activities were practically at a standstill. Physicians, dentists, veterinarians, sanitarians and hospitals were unanimous in their opinion that extensive importation would be necessary to maintain a minimum standard of medical care and treatment. This opinion was likewise shared by the general public.

Considerable criticism existed regarding Japanese policies as related to medical supplies for the civilian population. It was estimated that

two-thirds of medical supplies produced were taken by the Japanese Army and Navy. Although the government had set up rigid controls of production and distribution, the Army and Navy were allowed to fill their demands without regard to the needs of the civilian population. This practice served to create chaos and to encourage hoarding and marketing through unauthorized channels.

In planning to provide adequate medical supplies and equipment to meet the needs of the civilian population, the problem of utmost importance that confronted the Occupation Forces was (1) should all needed supplies be imported at the expense of the American taxpayer or (2) should every effort be made to increase and stimulate indigenous Japanese production and import only those materials, preferable in raw form, which would not be available in Japanese supply. It was decided that the latter course would be followed and immediate steps were taken to rehabilitate the Japanese medical supply and equipment industry.

Results of Surveys

Immediately upon arrival of the Occupation Forces, surveys were instituted to determine the status of medical supplies with respect to plan production capacity and availability of raw materials. Although pharmaceutical plants had been extensively damaged, potential capacity appeared to be adequate.

Data obtained from these surveys decided that concerted efforts should be made to reestablish medical supply production capacity by use of indigenous facilities and raw materials. Manufacturers were found to be very anxious to reestablish their plants and cooperated in mapping out an overall supply program.

The Japanese Government was directed to furnish the necessary medical, dental, veterinary and sanitary supplies and equipment required to maintain an adequate standard of medical care and treatment. Occupation Forces authorities were advised that United States-produced supplies were to be used only when Japanese resources were insufficient to prevent disease and unrest among the civilian population.

Responsible officials in the Ministry of Welfare were directed to develop procedures to carry out the supply responsibilities of the Ministry as well as develop necessary policies to establish an adequate supply program. These officials were trained and oriented so as to be able to support Occupation policies and to increase production and establish a workable distribution system.

Confiscation of Japanese Army-Navy Stocks

Immediately upon surrendering, all supplies and equipment of the Japanese Army and Navy were confiscated by the Occupation Forces. Non-war materials, such as medical supplies, were returned to the Japanese Government for civilian use, upon the completion of an inventory. These represented a sizeable stock. Steps were taken to require the Japanese Government to distribute these supplies to physicians, dentists, veterinarians, pharmacists, sanitarians and hospitals (See Chart No. 27).

A number of factors delayed this distribution project for most of the stocks were located in large depots and dumps, some in remote areas which made inventory, classification and transportation difficult. Officials of the Ministry of Welfare in addition to prefectural health and welfare agencies were supervised in organizing and carrying out of this program. The net result was a fairly sizeable quantity of supplies which could meet emergency needs and was a definite aid to the supply problem encountered at the beginning of the Occupation.

In the fall of 1946 special sales of former Japanese Army-Navy medical supplies and equipment were instituted throughout Japan, resulting in an accelerated rate of distribution of these items.

Supplies for Relief

The Japanese Government had made little progress in establishing a relief supply agency on a national level. Such relief supplies as were provided were furnished by various prefectural and private organizations. Relief supplies were considered to be a local problem and to a great extent were handled by neighborhood associations. When former Japanese Army-Navy supplies were released by the Occupation Forces, for civilian use, allocations of food and clothing for relief purposes were established by the Japanese Government. Stocks consisted of approximately 30,000 tons of canned meats, fish and biscuits and 3,000,000 pieces of clothing. As necessity developed, these supplies have been distributed to needy people under SCAP supervision.

The food was particularly useful in supplying indigents during the food deficit period that occurred in the summer of 1946. The Ministry of Welfare subsequently established a relief supply agency for the purpose of estimating requirements and directing distribution of relief supplies.

During the recent Fukui earthquake disaster in June 1948, Japanese disaster relief supplies including medicines, sanitary supplies, food and clothing were promptly moved into the stricken area. These supplies, stockpiled for such emergencies, were released by the Ministry of Welfare with SCAP approval. Amounts were adequate to meet all requirements.

Allocation of Raw Materials

In developing an over-all production program it was necessary that priority be assigned to production of essential supplies to effect full utilization of released stocks of raw materials. Special emphasis was placed on certain commodities. This was accomplished by the initiation of a plan designed to insure priority of production for the most essential and critical items.

The responsibilities of the Ministry of Welfare were clearly defined, and other Japanese agencies recognized the Ministry as the responsible agency for the supply of medical and sanitary materials. With the establishment of the Economic Stabilization Board, responsibility for the allocation of all raw materials was removed from the various industrial groups that had maintained a monopoly. The Drug Manufacturing Section of the Ministry of Welfare was designated as the agency responsible for recommending allocations of raw materials for medical supply industries.

The Ministry of Welfare has kept pace with the development of the Economic Stabilization Board, has assumed complete control of allocations made by the Board, and to date, has made definite and impartial allotments of raw materials and intermediates to all medical supply and equipment manufacturing plants. This was one of the most important developments in the medical supply program and permitted an effective coordinated system which basically enabled the industry to effect rapid production increase (See Charts Nos. 28, 29, 30).

Drugs and Chemicals

In expanding drug and chemical production, it was determined that the Japanese were uninformed on various new medicines. As the supply program developed, many new pharmaceuticals were produced in Japan for the first time.

The pharmaceutical industry had produced sulfa drugs prior to the termination of hostilities, but the amounts were not substantial and the quality questionable. A large portion of the production had been utilized in the manufacture of patent medicines.

With the utmost cooperation from the manufacturers, the production of sulfa drugs was increased several hundred percent and now meets current requirements. Modern drugs for the treatment of venereal diseases, such as mapharsen and bismuth subsalicylate had never been produced in Japan, but with the development of the venereal disease control program it became necessary to include these drugs on the production schedule. Here again, current production is now meeting requirements.

The additional quantities of coal and electricity that have now been made available to the medical supply industry has permitted an acceleration of all production programs. It has been possible to make further reductions in the imports of finished medicines due to the increases in Japanese indigenous supply. The program for the fiscal year 1949 includes only nine medicines in finished form as against the 1947 program of 39 medicines. Outstanding among those dropped from import are penicillin, sulfathiazole, insulin, mapharsen and bismuth subsalicylate.

Surgical Dressings

In the fall of 1946 a comprehensive production program of sanitary materials such as absorbent cotton, surgical gauze and bandages was instituted. The Japanese Government allocated imported raw cotton in the amount of 10,000,000 lbs. for the first year of the program and 20,000,000 lbs. each, for the second and third years.

While current requirements still exceed the supply, the production of these materials has rapidly increased each month, due principally to the increased allocations of fuel and electric power, so essential to maintain a firm production schedule. Continuing increases should shortly satisfy all demands (See Charts Nos. 31, 32, 33, 34, 35).

Penicillin

Although some laboratory research was in progress, penicillin had never been manufactured in Japan. The Japanese, being anxious to produce penicillin, initiated manufacturing primarily on a laboratory scale in the early part of 1946.

In the fall of 1946 a penicillin consultant from the United States was temporarily assigned for the purpose of instituting a comprehensive production program. In cooperation with the Ministry of Welfare, surface production was accelerated and considerable quantities of the drug were produced.

One of the projects undertaken by the penicillin consultant was the conversion from the surface production to the more rapid submerged method. Several companies have demonstrated their ability to produce by this submerged method, and the construction of pilot plants has progressed as fast as building materials permit.

Production during 1947 showed a steady increase throughout the year. While the surface method continues to produce the larger portion of the monthly production, continued progress is being made in the submerged method, as additional pilot plants are built and put into operation.

As production has increased, improvement and refinement of production techniques has been effected so that currently produced penicillin is now being packaged in standard 100,000 Oxford units per vial, as compared to the previous standard of 30,000 Oxford units per vial.

Rigid production standards are in effect in addition to assay tests at the National Institute of Health. Penicillin is now a non-controlled item and can be purchased freely by physicians, dentists, veterinarians and hospitals without restriction as to quantity.

Current production meets all requirements, June 1948 figures indicating 257,134 vials of 100,000 units each produced, an all-time high for this program. (See Chart No. 37).

Biologicals

Japan had maintained few disease immunization programs prior to the war. During hostilities they lapsed gradually, and at the cessation of hostilities, very few vaccines were being manufactured.

The production of vaccine was one of the first programs undertaken. Typhus vaccine and diphtheria toxoid production was introduced into Japan for the first time. During the first year of the occupation all essential types of vaccine production reached the minimum level required to carry out immunization programs. Importation was necessary in the case of typhus vaccine only. A small reserve of miscellaneous imported vaccines, established as an emergency measure in the beginning of the occupation, were used to supplement Japanese production.

The production of all types of vaccine and serum has now reached a satisfactory level and has increased to the point where no future imports are necessary in order to meet national requirements. With improvements in production techniques and standards of assay, which are carried out in the National Institute of Health, the biological production program has proven satisfactory and sufficient stocks are available to meet any emergency. (See Charts Nos. 38, 39, 40, 41, 42, 43)

Laboratory Animals

A program for production of laboratory animals became necessary to accomplish assays on the increased output of biologicals. This requirement was further increased due to the establishment of higher standards for these vaccines. A Japanese committee organized to solve this problem subsequently established a program providing for animal feed allocations and materials for construction of cages. This action, together with widespread publicity encouraging farmers to increase production, has accomplished excellent results.

The production of laboratory animals continued to increase month by month until September of 1947 when the disastrous Kanto regional flood destroyed the collection center for laboratory animals, located in Saitama Prefecture. However, renewed efforts to again resume production on the scale formerly attained resulted in increases until, currently, the requirements of all types of animals meet the needs of both the Japanese and Occupation Forces.

Medical and Dental Instruments and Equipment

Prior to the war Japanese doctors and dentists relied on foreign make instruments and equipment. Consequently, indigenous industry had a rapid development during the war, principally by copying foreign designs. However, quality was very inferior.

Like other industries, this industry suffered from war damage and conversion to war materials. Rehabilitation proceeded as fast as material supplies permitted. In cooperation with the Economic and Scientific Section of SCAP, concentrated efforts were made to stimulate production.

While quality still remains inferior due to lack of good raw materials, production has been steadily increased until current supply meets all demands. (See Charts Nos. 44, 45, 46)

Sanitary Supplies and Equipment

Japan's lack of sanitary standards, as covered more fully under Chapter 2, Preventive Medicine (Sanitation), and the sanitation program that has since developed, made it necessary that supplies and equipment be available to carry out the nation-wide project.

Large amounts of supplies and equipment were required for this program, and action was taken to utilize indigenous supply facilities to the greatest possible extent. As Japan has always been a large producer of pyrethrum flowers, it was possible to manufacture large quantities of effective insecticides. Under SCAP supervision, the Ministry of Welfare placed a production program in operation which has since produced enough pyrethrum emulsion to meet all requirements.

DDT was not being produced in Japan in sufficient quantities to carry out any worthwhile dusting program. The shortage of critical raw materials and the non-availability of facilities for mixing DDT dust or spray made it necessary to initially import finished products. During the first year of the occupation, however, action was taken to provide the necessary facilities and they were subsequently developed to mix packaged DDT products, utilizing imported DDT concentrate and indigenous plant facilities and deposits of pyrophyllite and talc.

This action not only resulted in considerable saving to the occupation cost, but stimulated Japanese interest resulting in a fast expansion of the DDT production program.

In the summer of 1947 production of DDT concentrate was instituted. Although some importation is still required, the increasing production figures have exceeded expectations.

Production of DDT concentrate has now reached a current monthly level of 15,000 kilograms. Except for small amounts of DDT concentrate imported to augment the Japanese indigenous supply, all importation of DDT products has been discontinued. It is anticipated that importation of DDT concentrate will be discontinued in the near future.

In addition to the noteworthy progress made in producing supplies for sanitary and insect and rodent control programs, programs for manufacture of spraying and dusting equipment were concurrently carried out. All types of powered and hand-operated dusting and spraying items have been produced for the nation-wide sanitation program. (See Chart No. 47)

Large adequate stocks of 10% DDT dust and 5% DDT residual effect spray as well as stocks of all types of necessary equipment are on hand to meet all requirements.

In addition, production of rat poisons, which was initiated along with the DDT program, has reached the point where distribution of rodenticides is no longer controlled, being handled through normal commercial channels (See Chart No. 48).

X-ray Film and Equipment

In the second occupational year the institution of an anti-tuberculosis program necessitated production of x-ray machines and x-ray film. After determining the number of machines available, a program to produce 100 photorcentographic, 35 mm. machines, was initiated and at the same time a program to produce necessary x-ray film was concurrently established.

This program continued satisfactorily until the required x-ray machines were produced. Monthly production of x-ray film now averages 28,000 square meters, which amount is adequate to meet the nation's needs. In view of the critical shortage of x-ray film in the United States, it has been necessary to supply a portion of Occupation Force requirements from Japanese production and in addition, film has also been exported to southern Korea to meet Korean civilian requirements (See Chart No. 49).

Hospital Supply Programs

The rehabilitation of hospitals, a necessity for improving medical care, was undertaken during the latter part of 1947. The Ministry of Welfare has computed requirements of fuels for heating and sterilizing in each hospital in Japan in addition to data on requirements of construction materials for improving the facility, including sanitary conditions.

The program for providing coal for use in hospitals has progressed satisfactorily and reports indicate that adequate quantities are being allocated and delivered. In addition, recent allocations of cement have been made to rebuild destroyed portions of hospitals or for new construction. These allocations have resulted in better medical care and improved sanitary standards.

The production increases in medical supplies and hospital equipment has permitted practically all hospitals to keep adequate stocks on hand. Except for some items such as surgical dressings which are still inadequate to meet all demands very few complaints have been received concerning medical supply shortages in hospitals.

Physical Improvement of Pharmaceutical Facilities

The recent availability of cement has also resulted in allocations being made to firms engaged in medical and pharmaceutical supply production. This has permitted many manufacturers to rebuild or partially rebuild parts of their damaged plants and has also permitted improvement to the plant facilities, thereby aiding production programs. More and more cement is becoming available each month and although it is still being handled on an allocation basis, based on a priority justification of the undertaking, it is anticipated that many medical and pharmaceutical industries will be able to increase their present production programs.

Evaluation of the Production Program

The success attained during the past three years in rehabilitating the Japanese medical supply and equipment industry is one of the most noteworthy achievements of the occupational mission. Without exception, Japanese medical supply firms, as a whole, are producing more than was ever produced in the history of the nation. (See Chart No. 50). In addition, they have produced many items which were not previously manufactured in Japan and current requests for strains of the new drug streptomycin from the United States will permit indigenous production of this product.

The standardization of all pharmaceutical products and assay of all biologicals is another new feature heretofore unknown in Japanese industry.

Production of all insect and rodent control supplies and equipment is meeting requirements and in addition, adequate stock piles are available in nine strategically located warehouses throughout the nation where emergency requisitions can be promptly filled.

The cooperation of various governmental and private officials has immeasurably aided the results that have been attained. Their enthusiasm, stimulated by guidance and supervision from SCAP personnel, has resulted in rapid progress being accomplished on many projects under the overall nation-wide programs.

Future Plans

The current program in effect will be continued with particular emphasis on the furnishing of cement and other construction materials

to completely rehabilitate the pharmaceutical and other medical supply industries and also to rebuild or repair hospitals, clinics, sanatoria, orphanages and other welfare institutions.

Another program is the supervision and guidance of trade associations and commercial, wholesale and retail agencies engaged in the purchase and sale of medical, dental, veterinary and sanitary supplies and equipment.

Expansion of production programs for those items which do not meet current requirements will be accelerated. Overall production standards will continue to be improved.

Distribution

The Distribution System

A thorough study was made of the distribution system. It was determined that to a great extent responsibility for distribution had been delegated to industrial groups. Professional associations of doctors, dentists, veterinarians, sanitarians, and pharmacists also assisted in the distribution of medicines and related supplies. The necessity for a thorough revision was recognized and plans were formulated to transfer responsibility for control of supply items to Japanese government officials.

Emphasis was placed upon refinements in the standard operating procedures which had been employed prior to the occupation. Numerous field visits and conferences were held with responsible national and prefectural officials, pointing out the necessity for more frequent distribution. As it had been the policy to distribute supplies on a quarterly basis, steps were taken to increase the frequency of distribution.

Included in the distribution program was an extensive repatriation project which required the distribution of large quantities of drugs, vaccines, surgical dressings, surgical instruments and appliances, hospital equipment and clothing. Under SCAP supervision the Ministry of Welfare found it necessary to ship vaccines and other medical supplies to China, Manchuria, Netherlands East Indies and other areas included in the repatriation program.

Although changes made in the distribution system permitted a more rapid flow of supplies to the consumer, it was still considered that a more effective plan could be placed in operation. Steps were taken to develop such a plan but in the interim the present system was continued in operation.

Controlled and Non-Controlled Medicines

At the beginning of the occupation certain medicines which were in short supply were placed on a controlled medicine list. Likewise, those medicines which were available in sufficient quantities to meet demands were placed on a non-controlled medicine list.

The controlled list originally included 365 medicinal items. However, as the production program developed and more drugs were produced for the Japanese consumers, the number of controlled items has greatly decreased.

In anticipation of a change in the distribution plan, which also affected the 45 most important items of medicines under control, shipments of these medicines were made direct from the manufacturers to dealers in the prefectures, designated by the prefectural governors. This plan by-passed the central and prefectural medicine distributing companies and greatly speeded up the distribution of these items.

The increases in medical supply production, including the development of new drugs, has resulted in controlled items currently being reduced to 85 medicines.

The New Ration System

The ration plan for distribution of controlled medical and sanitary items was promulgated by Ministry of Welfare Ordinance No. 30, dated 11 November 1947, becoming effective on 1 February 1948. The plan represents a radical change from the previous distribution system.

Based on anticipated needs, available items are allocated to prefectures by the Ministry of Welfare and to prefectural using agencies by prefectural officials. The supplies flow from manufacturer or importer through licensed central and local sellers to hospitals, practitioners, druggists and other authorized consumers and are obtainable upon presentation of ration credentials. Many of the evils of the former distribution plan have thus been eliminated and it has resulted in a more equitable and efficient flow of supplies.

The Central Medicine Distributing Company and the prefectural medicine distributing companies, pre-war organizations, have all been dissolved as of 31 December 1947 and 31 January 1948 respectively. The need for these institutions no longer exists since the ration plan for distribution of controlled items makes them superfluous.

Evaluation of the Program

The present distribution system of medical dental, veterinary, sanitary supplies and equipment is working very satisfactorily and has resulted in the consumer being able to obtain more medicines than heretofore possible.

Dental precious metals were placed on a rationed distribution plan effective 24 February 1948. This replaces the previous method of distribution through the Japan Dental Association.

Another item of importance handled through the distribution system was the recent allocation of U. S. Army surplus motor vehicles which were turned over to the Ministry of Welfare for use in public health and welfare activities.

The distribution program also provides for disaster relief supplies in the event of emergency.

The current system is not unlike that of the United States where the normal flow of supplies is from the manufacturer to the wholesaler, thence to the dealer and consumer. Freed from all government control except the necessity for rationing of critical items still short in supply, the present method has permitted the practicing doctor, dentist, veterinarian and sanitarian to obtain the medicines and drugs he requires with a minimum of delay (See Chart Nos. 51, 52).

Future Plans

Future programs provide for a continuation and improvement of the present distribution system. Also continued surveillance of control procedures to insure that governmental controls over distribution are kept to the minimum consistent with equitable allocation and distribution of critical raw materials.

Pharmaceutical Education

Introduction

Japanese pharmaceutical standards varied from manufacturer to manufacturer, there being no overall national standards existent. The pharmacist was not required to take an examination or obtain a license to practice.

The Pharmaceutical Education Council

One of the first steps taken to raise the educational standards of pharmacists was the formation of the Pharmaceutical Education Council. Frequent meetings of this Council has resulted in many recommendations for improving pharmaceutical standards. The Council has assisted in establishing school standards, rehabilitating school buildings and improving the curricula.

In cooperation with school inspectors which have now been established, frequent inspection trips are made by members of this Council to observe the efficiency of teaching techniques, if standards are being met and also to ascertain the morale of both the faculty and students.

The Council was instrumental in the drafting of the new Pharmaceutical Law and have also acted as advisors to the reorganized Japan Pharmacists Association.

The Pharmacists Association

The Japan Pharmacists Association formerly under strict government influence has now been reorganized under democratic principles. Provisional election of officers was accomplished in June 1948 pending the first regular election to be held in August. Membership is limited to licensed pharmacists with 20,000 applications having been received to date.

Pharmacists have evidenced considerable enthusiasm in improving their standards and the current availability of all types of drugs has stimulated their interest in forming an association that will receive proper professional recognition.

The Pharmaceutical Law

The need for a pharmaceutical law was recognized early in the occupation. However, it was first necessary to rehabilitate the medical supply industry as well as improve pharmaceutical educational standards before an attempt could be made to draft a law that would meet the needs of the nation. In 1947 preliminary work was begun and after many months of study and conferences with Japanese officials and members of the Pharmaceutical Education Council a bill was presented to the Diet and became law on 30 June 1948.

The law provides that all drugs, devices and cosmetics meet the requirements and conform to the standards set by the Ministry of Welfare. These standards are recommended by the National Board of Pharmacy which was established under the provisions of this law, with members appointed from among leaders in the fields of medicine, pharmacy and education.

The law further provides that pharmacists, in order to apply for license, must have graduated from an accredited college or university and have passed the National Pharmacist Licensure Examination given by the National Board of Pharmacy. The illegal sale or other distribution of poisons and powerful drugs, including sulfanilimide and its derivatives, penicillin and streptomycin is prohibited except pursuant to the prescription or under the direction of a licensed physician, dentist, veterinarian or surgeon.

This law is a most comprehensive and modern law which establishes pharmaceutical standards heretofore unknown to the Japanese.

Future Plans

Future plans provide for a continuance of the educational programs currently established and also surveillance of the recently enacted Pharmaceutical Law to determine that all of the law's requirements are being met.

Budget and FinanceThe Ministry of Welfare Budget

The Japanese fiscal year covers the twelve-month calendar period from 1 April through 31 March. All necessary appropriations recommended by the Ministry of Welfare for carrying out the nation-wide public health and welfare program are reviewed by the Public Health and Welfare Section. The amount of the budget is determined by estimates submitted by the various ministerial bureaus and sections and consolidated by the Ministry. This requires very minute analysis as the Japanese economy has to be considered in relation to the need of the many and various public health and welfare projects.

Past budgets, with occasional supplemental appropriations, have proven adequate in providing for those projects considered necessary to maintain an effective public health and welfare program. For the Fiscal Year 1948 (1 April 1948 through 31 March 1949) the Ministry of Welfare recommended a budget of ¥ 15,246,305,876. After considerable revision due to the necessary expansion of several public health projects, the Ministry of Finance approved a budget of ¥ 15,445,786,000. However, in view of recent salary increases throughout the nation, including governmental workers, this budget is not now considered sufficient to carry out all the planned projects and an increase of approximately ¥ 850,000,000 has been requested.

Fund Allocation

While the Ministry of Welfare is responsible for the overall nation-wide public health and welfare program they do not financially support the total cost of the various projects. Dependent upon the financial status of the prefectures, the Ministry provides grants-in-aid for most programs, the balance of the funds being met by prefectural or local appropriations. All allocations to the prefectures, however, and the amount that the prefectures can contribute, receive careful analysis to determine that allocations are consistent and impartial and that the money is being spent for useful purposes. As an average the National Government contributes about 50% of all project costs.

Budgetary Control

Due to Japanese unfamiliarity with budgetary control and fiscal procedures, considerable supervision and more or less on-the-job training has taken place to acquaint them with their responsibilities in matters pertaining to the support of public health, public welfare and social security programs. This training, being continued, is resulting in the responsible officials exercising more care in analyzing budgetary matters and also in determining that budget requests are proper and justifiable.

Chapter 10

NARCOTICS

Pre-Occupational Summary

No control over narcotics existed in Japan at any time prior to the surrender. Emphasis was placed on production of narcotics, from opium and coco leaves imported from Manchuria, Mongolia, Formosa, Iwo Jima, Okinawa and the Middle East, with complete disregard of international obligations to limit and report such transactions to bodies charged with regulating the supply and distribution of narcotics throughout the world.

Figures of production, as furnished by the manufacturers to the Japanese Government, were maintained in Japanese Government files but "planned" figures showing, for instance, one-sixth of the actual production of heroin, were submitted to the Supervisory Body of the League of Nations as true figures. Heroin was shipped from Japan and Korea to Manchuria in quantities that would more than suffice for total world requirements.

At the beginning of the occupation, narcotics, both finished and crude, were scattered throughout Japan in caves, medical depots, Army and Navy hospitals and other military and industrial establishments.

Japanese reports always indicated a comparative scarcity of narcotic addicts. This was contrary to presumptions since any doctor or pharmacist in Japan could purchase and dispose of any amount of narcotics without being required to maintain records.

Prohibition of Growth, Manufacture and Exportation

After determining the laxity of controls that existed over narcotics in Japan, the Japanese Government was immediately directed to:

1. Prohibit the planting, growth and cultivation of narcotic seeds and plants.
2. Prohibit the manufacture and exportation of narcotics.
3. Enact laws establishing strict centralized control over narcotics.
4. Establish a narcotic enforcement agency extending throughout every prefecture in Japan.
5. Destroy all heroin, a high-tension, dangerous narcotic formerly reaching illegal markets in the United States.

It was decided that importation of narcotics would be limited to the amounts deemed necessary for medical treatment of the Japanese people. In the fall of 1945 after the growth, manufacture and exportation was prohibited, all crude and semi-processed narcotics were taken into custody by the occupation forces. All former Japanese Army and Navy medicinal narcotics were likewise taken into custody, inventoried and stored. These medicinal narcotics have since been turned over to SCAP approved wholesale houses for repackaging and distribution under strict control regulations which were enacted into Japanese law in June 1946 and incorporated into a new law passed by the Diet on 28 June 1948.

Establishing Narcotic ControlNarcotic Regulations

Legislation establishing a strong centralized control over the distribution of narcotics by dealers was enacted following six months of

conferences and preparation. The dealers, numbering approximately 84,000 must register annually and submit periodic reports. Every transaction by the dealers, who are required to follow prescribed procedures, is reported monthly to the Japanese Government through prefectural offices and, in turn, forwarded to SCAP. These summaries are accurate statements on the working stock (wholesaler's stocks) of narcotics in Japan and give detailed information of violations, seizures, thefts, arrests and convictions.

These controls were the result of ministerial regulations. It was recognized that a new narcotic law, to embody all the principles of effective narcotic control, was essential. After numerous conferences, a proposed bill was submitted to the Diet and became law on 28 June 1948, effective from 10 July 1948.

The new Narcotic Control Law continues in effect as law the strict provisions of SCAP directives and ministerial regulations under which narcotics have been brought under control during the past three years. The law provides that persons who are addicted to narcotics so as to be menace to the public welfare because of their addiction, or to lose their self-control because of their addiction, shall be subject to penal servitude of not less than six months, nor not more than one year. The maximum penalty under the law is five years penal servitude or ¥ 50,000 fine, or both. There is a gradation of penalties written into the law to encourage the courts to assess severe penalties for willful violations.

Regulations effectuating the provisions of the Narcotic Control Law were promulgated on 13 July 1948.

In addition to the Narcotic Control Law, a Marihuana Control Law also passed the Diet on 28 June, effective from 10 July 1948. This law provides that marihuana can only be grown for fibre purposes. It limits the areas for such production and continues in effect the strict controls which have been operative as the result of SCAP directives.

The maximum penalty provided by the law is three years penal servitude or ¥ 30,000 fine, or both.

A Poison Control Law passed by the Diet on 3 December 1947 regulates the manufacture, labeling, storage and distribution of poison and powerful agents. Records of sales must be maintained and sales to persons under 14 years of age are prohibited.

The Pharmaceutical Affairs Law, which passed the Diet on 30 June carries a provision that a drug containing any quantity of narcotics or hypnotic substance shall carry a label with the name, quantity and percentage of said substances and derivatives thereof and in juxtaposition thereto, the quotation, "Warning - May be Habit Forming".

Narcotic Enforcement Agents

During the first occupation year basic principles of proper narcotic control were firmly established. In cooperation with government officials a Narcotic Section of 40 persons was created in the Ministry of Welfare on 2 April 1947.

Upon the inauguration of the Narcotic Section, plans were implemented to appoint narcotic agents throughout each prefecture in Japan who would supervise and investigate narcotic control in their respective areas. These agents, now numbering 200, received judicial power of arrest for narcotic violations in September 1947.

Diet action, in granting police power to narcotic agents, made law enforcement much more effective. In December 1947 these agents, working

with Occupational Force law enforcement personnel, were responsible for apprehending a group of foreign nationals who were illegally dealing in heroin and opium proved to have originated outside of Japan. Thefts of narcotics were curtailed by limiting the purchases of narcotics by registrants, who were burglarized, to minimum amounts until they improved storage security and received approval by the Narcotic Section.

The following is a summation of narcotic control enforcement activities in Japan for the 18 months ending 30 June 1948:

Registrants inspected	39,157
Investigations originated	3,315
Arrest - Registered persons	286
Unregistered persons	815
Total	1,101
Conviction - Registered persons	94
Unregistered persons	357
Total	451

Of registrants convicted 27 received sentences totaling 25 years 9 months penal servitude and 67 received fines totaling ¥ 166,946. Of non-registrants convicted 172 received sentences totaling 209 years 6 months penal servitude and 74 received suspended sentences totaling 146 years 6 months. Two hundred sixty-two non-registrants including 61 of those sentenced to penal servitude, were fined a total of ¥ 697,400.

Thefts averaged 37 per month in 1947. This has been reduced to 29 per month through June 1948.

Agents operate under supervision and direction from new narcotic officials in the Ministry of Welfare who have no connection with the former narcotic policy in Japan. They work in close liaison with the police and receive continuing instruction and guidance in narcotic investigative procedures from SCAP narcotic control personnel.

Training Schools

In March 1948 a training school was held in Tokyo for the chief narcotic agent from each prefecture in Japan. Practical demonstrations were given by SCAP narcotic control personnel, officials of the Narcotic Section, Ministry of Welfare, and officials of the Prosecution Section, Attorney General's Office.

In May 1948 a second such school was held in Tokyo. A third school is planned for the fall of 1948 to train the remaining narcotic agents in modern investigative procedures including their authority with judicial power of arrest.

These schools have immeasurably aided enforcement personnel in becoming more familiar with their responsibilities.

Cultivating Hemp for Fibre

Economic necessity, as well as the marked advances made in the proper control of narcotics, made it imperative that certain changes be made in the narcotic control program.

In January 1947, to relieve the acute shortage of fishing ropes and nets, hemp was authorized to be cultivated for fibre purposes in

certain areas limited to an overall total of 5,000 hectares (1 hectare equals 2.45 acres). The authority to grow hemp is now contained in the new Marihuana Control Law.

Sales and Distribution

Sales and distribution of narcotics are strictly controlled under the new Narcotic Control Law. Wholesalers and dealers are required to submit reports of all transactions each month and careful surveillance is maintained over these wholesalers and dealers through regular inspections by narcotic enforcement agents. In addition, all wholesalers or dealers are required to maintain proper security storage for all narcotic stocks with the vaults of wholesalers being further required to have proper sanitation, etc. Access to such areas is not permitted to any person who is not authorized and properly identified. Employees of wholesale firms are carefully screened and selected.

Druggists' and pharmacists' records are carefully checked by narcotic enforcement personnel and discrepancies are promptly handled by warning the dealer and in cases of willful violation, prosecution follows.

Narcotics which were regarded as the most difficult item to control in Japan were the first medicines to be placed on a free-trade basis for distribution.

Prices are controlled and sales are restricted to minimum amounts as needed by registrants. Every transaction must be made a matter of record, including the narcotics administered to a patient by a practitioner.

Accurate reports, which are assembled by the Japanese Government covering every phase of the narcotic control program, are forwarded to the United Nations Commission on Narcotics and to the United Nations Opium Board. Favorable comment has been received from these agencies regarding the effective control measure now operative and also the manner in which enforcement has been carried out.

Narcotic Addicts

Japanese reports prior to the occupation have always indicated a comparative scarcity of narcotic addicts. Due to data obtained on the laxity of narcotic control a continued effort has been made to determine the number of addicts in Japan and has resulted in information on approximately 4,890 such persons. Such addicts are kept under surveillance and the new narcotic law provides that treating an addict with narcotics is prohibited.

Under the new law addicts can be hospitalized and given treatment cures until considered under control and not a hazard to the public welfare.

Future Plans

Japan has been eliminated as a source of illicit narcotic trafficking and narcotic officials in the Ministry of Welfare and the narcotic enforcement agents throughout the nation have performed a commendable job in carrying out their responsibilities.

Future programs will be directed toward improved narcotic medication standards, in addition to improving enforcement control by narcotic agents as well as prefectural procurators who present all narcotic violations to the courts.

Improved security measures to be undertaken by registrants holding large stocks of narcotics will tend to prevent diversions and limit trafficking into underworld sources. Special cognizance will be taken of any attempt to establish any international lines of trafficking either into or out of Japan.

